LILIYA GERSHENGOREN M.D.

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Email Communication Informed Consent

Patient Name: _____

Date of Birth: _____

Email Address(es): _____

Phone Number: _____

I understand that communication by email may not be secure. There is some risk that any protected health information (PHI) contained in email or text message can be intercepted in transmission by unauthorized third parties or misdirected. There is no assurance of confidentiality when communicating this way.

Any sensitive information is best communicated by telephone, fax, or mail. Your use of email to communicate PHI indicates that you acknowledge and accept the possible risks associated with such communication.

You must provide your consent, recognizing that email is not a secure form of communication.

I will use the minimum necessary amount of PHI to respond to your query.

Please do not use email or text message to communicate about a medical emergency.
There is no guarantee that I will be able to respond to email communications on the same day.

This consent form will be considered valid for the duration of your treatment, until revoked in writing.

If you wish to conduct communications regarding your medical issues via email, please indicate your acceptance of this risk by signing below.

_____ _____

Patient Signature **Date**