Canyon Eye Associates

MRN#_____

Patient Consent for Email Communication of Protected Health Information (PHI)

I, _____, understand the following:

- **PHI:**
  This form relates to my Protected Health Information (PHI), which is information that can be used to identify me and is related to my health or treatment.
- **Email Communication:**
  I understand that my healthcare provider may communicate with me via email regarding my health and treatment.
- **Risks:**
  I understand that email communication, while a convenient method, may not be as secure as other forms of communication. There is a risk of unauthorized access, interception, or misuse of my PHI if my email account is compromised.
- **Safeguards:**
  My healthcare provider will take reasonable safeguards to protect the security of my PHI transmitted via email. These safeguards may include encryption, secure email providers, and password protection of devices.
- **Revocation:**
  I understand that I have the right to revoke my consent to receive PHI via email at any time. I will inform my healthcare provider in writing of my decision to revoke this consent.

I, _____, consent to the following:

- **Communication via Email:**
  I agree to receive communications containing my PHI via email from my healthcare provider.
- **Acknowledgement of Risks:**
  I acknowledge the potential risks associated with email communication, including unauthorized access, interception, or misuse of my PHI.

By signing below, I confirm that I have read and understand the terms of this consent form.

_____ _____

Patient Signature Date

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