

GMD SPECIALIST MEDICAL CLINIC
CONSENT TO USE ELECTRONIC COMMUNICATIONS

PATIENT INFORMATION:

Name: _____

Address: _____

Email: _____

Mobile Phone: _____

The Physician has offered to communicate using the following means of electronic communication (“the Services”):

Email	Videoconferencing (including Zoom®, Facetime®)
Text message	Medeo Secure Messaging

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication services. I understand and accept the risks outlined in this consent form, associated with the use of the Services in communications with the Physician and the Physician’s staff. I consent to the conditions and will follow the instructions outlined in this form, as well as any other conditions that the Physician may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician’s staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician’s staff using these Services with a full understanding of the risk.

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice.

Patient signature: _____ | Date: _____