Suite 201, 505 Queen Street Spruce Grove, AB T7X 2V2
780-962-9888 Fax 780-960-5298

Patient Email Communications Consent Form

Patient Name: _____PHN: _____ Email address: _____

Child/Dependant Name: _____PHN: _____ Email address: _____

Child/Dependant Name: _____PHN: _____ Email address: _____

Child/Dependant Name: _____PHN: _____ Email address: _____
(Please note, every family member must have a unique email address)

I authorize my doctor and/or their staff to communicate information with me regarding aspects of my healthcare through the above email address. My signature below denotes that I have read this document, Patient Email Communications Form, and accept the risk of loss of privacy of confidential health information associated with electronic communications.

I agree that Dr. _____ may, at their discretion, offer the opportunity of participating in clinical studies, quality improvement initiatives, or other activities that could benefit me and my health via the above email address. However, my email address will not be shared with any other agency or organization without my explicit consent.

I agree that Dr. _____ and/or their staff shall not be liable for any type of damage or liability arising from or associated with the loss of confidentiality due to electronic communication that is not caused by the health care providers or the staff's intentional misconduct. I understand my health care provider will use reasonable means to protect the security and confidentiality of electronic information sent and received. However because of the risks, my healthcare provider cannot guarantee the security and confidentiality of electronic communications. Further, I understand that my health care provider does not guarantee this means of communication will be free from the technological difficulties including but not limited to loss of messages and delay in transmission.

This authorization for communication by means of electronic communication is valid until I notify the health care provider list above in writing, that I no longer authorize the use of email to communicate information concerning my healthcare. I understand that information communicated by email may be retained within my health record. My health care provider also retains the right to terminate email as a communication tool if it becomes burdensome or is used inappropriately.

Signature of Patient/substitute Decision Maker: _____

Date: _____