PATIENT CONSENT FOR USE OF EMAIL

PATIENT'S INFORMATION

Name: _____
MR#: _____
DOB: _____
Date: _____
Address: _____

Email address: _____

RISKS OF USING EMAIL

University of California, Davis, Medical Center (UCDMC) offers patients the opportunity to communicate by email. However, before patients elect to communicate with UCDMC via email, patients should consider the risks involved in transmitting patient information by email. These risks include, but are not limited to, the following:

→ Email can be circulated, forwarded, and stored in numerous paper and electronic files. Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
→ Email senders can easily misaddress an email.
→ Email is easier to falsify than handwritten or signed documents.
→ Backup copies of email may exist even after the sender or recipient has deleted his or her copy.
→ Employers and on-line services have a right to archive and inspect emails transmitted through their systems.
→ Email can be intercepted, altered, forwarded, or used without authorization or detection.
→ Email can be used to introduce viruses into computer systems.
→ Email can be used as evidence in court.

CONDITIONS FOR THE USE OF EMAIL

UCDMC will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, UCDMC cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by UCDMC's intentional misconduct. Thus, patients must consent to the use of email for patient information, including agreement with the following conditions:

1. All emails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.

2. UCDMC may forward emails internally to UCDMC's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. UCDMC will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
3. The patient is responsible for informing UCDMC of any types of information the patient does not want to be sent by email.
4. The patient is responsible for protecting his/her password or other means of access to email. UCDMC is not liable for breaches of confidentiality caused by the patient or any third party.
5. UCDMC shall not engage in email communication that is unlawful, such as unlawfully practicing medicine across state lines.
6. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS

To communicate by email, the patient shall:

1. Limit or avoid use of his/her employer's computer or any publicly accessible computer.
2. Immediately inform UCDMC of changes to his/her email address.
3. Put the patient's name in the body of the email.
4. Include a description of the subject of the email (e.g.,"billing question") in the email's subject line for routing purposes.
5. Review the email to make sure it is clear and that all relevant information is provided before sending to UCDMC.
6. Acknowledge receipt of each email from UCDMC.
7. Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding his/her computer password.
8. Withdraw consent to use email only by email or written communication to UCDMC.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form, understand the risks associated with the communication of email between UCDMC and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that UCDMC may impose to communicate with patients by email. Any questions I may have were answered.

_____	_____
Signature of patient or representative	Date
_____	(____)_____
Print Name	Telephone Number
_____	
Relationship to patient (if other than patient)	
_____	_____
Witness signature	Date