# ROBERT L. POTEMPA, D.P.M., FOOT & ANKLE
# E-mail Consent Form

Patient Name: _____
Date of Birth: _____

E-mail address: _____
phone number: _____

Robert L. Potempa, D.P.M., Foot & Ankle Clinic, offers our patients the opportunity to communicate by e-mail. This form provides information about the risks of e-mail, guidelines for e-mail communication and how we will use e-mail communication. It also will be used to document your consent for us to communicate with you by e-mail.

**RISKS**

Communication by e-mail has a number of risks which include, but are not limited to, the following:

- o E-mail can be circulated, forwarded and stored in paper and electronic files.
- o Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- o E-mail can be received by unintended recipients.
- o E-mail can be intercepted, altered, forwarded or used without authorization or detection.
- o E-mail senders can easily type in the wrong e-mail address.
- o E-mail can be used to introduce viruses into computer systems.

**HOW WE WILL USE E-MAIL**

1) We will limit e-mail correspondence to established patients who are adults 18 years or older, or the legal representatives of established patients.
2) We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as:

- o Questions about prescriptions, use of medical equipment or devices, etc.
- o Routine follow-up questions
- o Appointment scheduling
- o Billing questions

3) All e-mails to or from you will be made a part of your medical record. You will have the same right of access to such e-mails as you do to the remainder of your medical file.
4) Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling.
5) We will not disclose your e-mails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.
6) If you request, we will e-mail your health information to you or to a third party designated by you.

**IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL…CALL 911.** Also, do not use e-mail for **urgent problems**. If you have an urgent problem, call our office [office phone number] or go to an urgent care facility.

**GUIDELINES FOR E-MAIL COMMUNICATION**

1) Include the general topic of the message in the "subject" line of your e-mail. For example, "advice," "prescription," "appointment" or "billing question."
2) The e-mail message should not be time-sensitive. While we try to respond to e-mail messages daily, it may take up to three (3) working days for us to respond to your message. Urgent messages or needs should be relayed to us using regular telephone communication.
3) Include your name and phone number in the body of the message.
4) Review your message to make sure it is clear and that all relevant information is included before sending.
5) Send us an e-mail confirming receipt of our message after you have received and read an e-mail message from us.
6) If your e-mail requires a response from us, and you have not heard back from us within three (3) working days, call our office to follow-up to determine if we received your e-mail.
7) Take precautions to protect the confidentiality of e-mail, such as

safeguarding your computer password and using screen savers.

**CONSENT**

I, _____, am:
*(print name)*

____ a) an established patient of [name of doctor or office practice].

____ b) the legal representative of an established patient,

_____
*(print patient's name)*

I may want to communicate with [name of doctor or office practice] and the office staff by e-mail. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form. I understand that [name of doctor or office practice] cannot guarantee the security and confidentiality of e-mail communication. [name of doctor or office practice] will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with [doctor or office practice name] by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.

8) Inform us of changes in your email address.

I understand that either I or [name of doctor or office practice] may stop using e-mail as a means of communication upon my written request.

I understand that I may revoke this consent at any time by so advising [name of doctor or office practice] in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from [name of doctor or office practice].

_____
(print name)

_____
(signature)

_____
(date)

**** Keep the original or top copy in the patient's medical record and give the patient a copy for his/her reference.***