



BELL CENTER FOR ANXIETY AND DEPRESSION

Patient - Provider E-Mail Communication Authorization

Keep in the patient's medical record

I allow the Bell Center for Anxiety and Depression to use electronic mail (e-mail) to communicate clinical information to me pertaining to health care services that I have received. I acknowledge and understand that e-mail communications may contain my personal and private medical information including, but not limited to, my name, address, date of birth, types and dates of health care services received, medication, insurance coverage information, and/or test results.

I understand that, although the Bell Center for Anxiety and Depression may attempt to protect the privacy of the contents of e-mail sent to me and will take reasonable measures to protect my privacy, *the e-mail messages sent to me are not encrypted and travel over the Internet. As a result, there is a risk that the e-mail will be intercepted and read by unauthorized third parties.* In allowing the Bell Center for Anxiety and Depression to send me e-mail, I assume this risk.

I also acknowledge and understand the following as it relates to this e-mail communication:

1. E-mail is not appropriate for conveying information relating to urgent or emergency medical matters. If I am experiencing an urgent or emergency situation, I understand that I should dial 911 immediately.
2. If an e-mail has not been answered, I should call to make sure that it has been received and I may make an appointment to see/speak with the health care provider to discuss the e-mail message.
3. I will not use e-mail for discussion of sensitive or highly confidential issues; for example, mental health or reproductive issues, etc. If there are specific types of information that I do not want included in emails (e.g., lab results), it is my responsibility to notify the Bell Center for Anxiety and Depression.
4. Employees of the Bell Center for Anxiety and Depression, other than the Provider, may have access to my e-mail address and e-mail content such as triage nurses, consulting physicians, and other health care providers that are permitted access to my medical records.
5. I, and not the Bell Center for Anxiety and Depression, am responsible for the security of e-mail communications sent from or stored on my computer.
6. My decision to allow the Bell Center for Anxiety and Depression to communicate with me by e-mail is voluntary, and treatment is not conditioned upon my election to do so.
7. The Bell Center for Anxiety and Depression or I may stop e-mail communication at any time for any reason.
8. I agree to notify the Bell Center for Anxiety and Depression when my e-mail address changes.
9. I will not hold the Bell Center for Anxiety and Depression responsible for damages resulting from their use of e-mail or the failure of any the Bell Center for Anxiety and Depression information systems used to facilitate the e-mail communication.
10. I understand that all e-mails related to my care received or generated by the Bell Center for Anxiety and Depression will be maintained in my medical record.

The Provider may send medical information to my e-mail address, which is:

E-mail Address:

The Provider may communicate via e-mail to the designated individual listed below.

Name:	Relationship to Patient:
E-mail Address:	

Patient Name (Print):	Patient/ Patient Representative Signature:	Date:
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