life
medical clinic

AUTHORIZATION FOR PATIENT EMAIL AND VIRTUAL COMMUNICATIONS

Full Name

Date of Birth Healthcare #

I am hereby authorizing my care team at Life Medical Clinic to contact me through my email which I have confirmed as _____ .

(Email for patient)

I understand that Life Medical Clinic will not be held liable for any type of damage associated with the loss of confidentiality due to virtual or electronic communication. I understand my health care provider will take reasonable measures to protect the security and confidentiality of electronic information sent and received, but due to the risks of electronic communications my healthcare team cannot guarantee the security and confidentiality of these communications.

I know that by signing this authorization, I take all responsibility for ensuring my email and any device and internet source used to access this email is reasonably secured, and will contact my healthcare team if there are any changes to my email address or contact information. I understand that I may cancel this authorization in writing if necessary in the future.

I understand that this is not considered a secure or confidential method of communication, and information will be released through email at my care team's discretion. I know that email communications may be saved in my health record, and that my care team may cease email and virtual communications if used inappropriately.

I fully understand and accept the risks and limitations for use of electronic communications.

Signed:_____

Print Name: _____

Date:_____