

CONSENT TO COMMUNICATE

MARINA
PLASTIC SURGERY

THE INSTITUTE
COMPREHENSIVE SKIN CARE
MARINA OUTPATIENT SURGERY CENTER

PATIENT: _____

EMAIL: _____

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
<input type="checkbox"/> Call Work Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Call Cell Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Call Home Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Ok to send Email ?				
Email Appointment Reminders	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Email Office Specials	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Email Medical Info/Communicate with Staff	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Ok to send Regular Mail? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Ok to send Text Message for Appointment Reminders? <input type="checkbox"/> Yes <input type="checkbox"/> No				
-if yes, please list cell phone carrier (e.g., AT&T):				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message or discuss health information with another person, please list them:

Name	DOB	Relationship	OK to Discuss Health Information	Any Comments
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please list your **Emergency Contact(s)**:

Name	DOB	Relationship	Contact Number

Signature: _____

Date: _____

PATIENT REQUEST FOR EMAIL COMMUNICATIONS

PATIENT: _____ **DOB:** _____

EMAIL: _____ **CONTACT #:** _____

Communications over the Internet and/or using the email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicated via email.

Please be advised that: This request applies to Marina Plastic Surgery Associates, Comprehensive Skin Care, The Institute, Marina Outpatient Surgery Center, Grant Stevens, MD, Inc., and/or associated staff.

I understand and agree to the following:

- I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form and I have read and understand it.
- I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicate this day.
- I understand that all email communications in which I engage may be forwarded to other providers for purposes of providing treatment to me.
- I agree to hold Marina Plastic Surgery Associates, Comprehensive Skin Care, The Institute, Marina Outpatient Surgery Center, Grant Stevens, MD, Inc., and/or individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

PATIENT / GUARDIAN SIGNATURE

DATE

If personal representative, authority to act on behalf of patient

IMPORTANT INFORMATION ABOUT PATIENT EMAIL

As a patient of Marina Plastic Surgery Associates, Comprehensive Skin Care, The Institute, Marina Outpatient Surgery Center, or Grant Stevens, MD, Inc., you may request we communicate with you by electronic mail (email). This Fact Sheet will inform you about the risks of communicating with our office and how we will use and disclose provider/patient email.

PLEASE READ THIS INFORMATION CAREFULLY

Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition.

If you have an urgent or an emergency situation, you should not rely solely on provider/patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider/patient email is not available to you – and seek assistance by means consistent with your needs.

Email messages on your computer, your laptop, and /or your phone have inherent privacy risks-especially when your email access id provided through your employer or when access to your email messages is not password protected.

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

Email messages may be inadvertently missed. Email is sent at the touch of a button. Once sent, and email message cannot be recalled or cancelled. Errors in transmissions, regardless of the sender's caution, can occur.

In order to forward or to process and respond to your email, associate staff may read your email message. Your email message is not a private communication between you and your treating provider.

Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Email can be misinterpreted.

At your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.

PLEASE RETAIN, THIS IS FOR YOUR RECORDS