

PATIENT REQUEST FOR EMAIL COMMUNICATION

**Communications over the Internet and/or using the email system are not encrypted and are inherently insecure. There is no assurance of confidentiality of information when communicated this way.** Nevertheless, you may request that we communicate with you via email. To do so, you must complete this form and return it to our office.

Please be advised that:

- 1) Your Request will not be effective until you receive and respond appropriately to a test email message from our practice. Please select the test question you want to use below and provide us with your answer.
- 2) Email Restrictions: Email is not checked in a regular manner hence anything you may say will not be conveyed to the care provider in an appropriate manner. Any & all medical questions or concerns are best dealt with & should be dealt with via a telephone call or in-person visit. If you are experiencing any medical emergencies, please dial 911
- 3) Email access is a privilege and a service convenience. The practice holds the full right to discontinue email communication with any patient at any time without any reason or notice.

Please provide the following information:

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please specify the email address to which communications should be addressed:

\_\_\_\_\_

Emails available to use: [office@dlmdpa.com](mailto:office@dlmdpa.com)  
[nurse@dlmdpa.com](mailto:nurse@dlmdpa.com)  
[billing2@dlmdpa.com](mailto:billing2@dlmdpa.com)  
[officemanager@dlmdpa.com](mailto:officemanager@dlmdpa.com)

Please initial each blank and sign below:

\_\_\_\_\_ I certify the email address provided on this Request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.

\_\_\_\_\_ I have received a copy of the IMPORTANT INFORMATION ABOUT PROVIDER/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 are not encrypted and are inherently insecure; that there is no assurance of confidentiality of information when communicated this way.

\_\_\_\_\_ I understand that all email communications, in which I engage may be forwarded to other providers, include providers not associated with this practice, for purposes of providing treatment to me.

\_\_\_\_\_ I agree to hold the practice and individuals associated with it harmless from all claims and liabilities arising from or related to this Request to communicate via email.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date