RIDGEVIEW Medical Centre

EMAIL CONSENT FORM

Patient Name:	Patient Date of Birth:
Patient Email:	Patient Address:

Ridgeview Medical Centre supports the use of email for the purpose of communicating with our patients regarding their clinical care. A care provider may agree to communicate with you using email but is not required to do so. You may choose to communicate with the clinic using email but you are not required to do so.

Signing this consent form provides the clinic with your permission to communicate with you via email and is required before we will respond to your email or send you email for the first time. This consent can be withdrawn at any time by contacting the clinic by phone or in person.

If you choose to communicate with the clinic via email, you should be aware that email messages you send to or receive from the clinic:

- May not be secure. The clinic cannot guarantee the security of any email message transmitted outside of our email system;
- May exist as an electronic or paper record within the clinic indefinitely.

For these reasons, if you use email to communicate any information, including personal health information, to the clinic, or to receive any information, you are hereby accepting the inherent **risk of this information being compromised**.

THE CLINIC CANNOT GUARANTEE THAT YOUR EMAIL WILL BE RECEIVED, READ OR RESPONDED TO WITHIN ANY PARTICULAR PERIOD OF TIME. YOU MUST NOT COMMUNICATE WITH THE CLINIC VIA EMAIL FOR MEDICAL EMERGENCIES OR OTHER TIME-SENSITIVE MATTERS.

TERMS OF USE

I understand that it is my responsibility to monitor email received at the indicated email address(es) and to advise the clinic in writing if any email address changes or should no longer be used by the clinic for email communications with myself. I understand that only this email address will be used by the clinic for communication to me.

If I am signing on behalf of my minor child, I understand that when he/she turns 13 this consent will be void and the child will have the option of signing his/her own consent for ongoing email communication with the clinic.
I understand that the clinic cannot guarantee the security of email messages that I send to or receive from the clinic.

I agree not to use email to communicate emergency or urgent information about myself and understand that the clinic does not guarantee the receipt or review of any email messages that I may send to the clinic.

I understand and agree that individual care providers may make decisions about my treatment based on information I provide through email and that this information may form part of my health record.

I understand that email communication is not a substitute for clinical examination and that I may be required to attend the clinic in-person to have my concerns assessed.

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I understand that I may stop using email for clinical communication purposes at any time, at which point I will notify the clinic in writing of my decision to stop using email for these purposes. I understand that this consent remains effective unless and until it is withdrawn.

I understand that individual care providers may stop using email for clinical communication purposes at any time, at which point s/he will inform me in writing or notify me about this decision at the time of my next appointment.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with email communication and consent to the conditions outlined herein, as well as any other conditions that the Physician may impose to communicate with patients by email. I acknowledge the Physician's right to withdraw the option of communicating through email. Any questions I may have had were answered.

Consent for Patients Over Age 13

I, _____, confirm that I have read and agree to these terms and I wish to communicate via email for the purposes of my clinical care.

Signature: _____ Date: _____

Consent for Guardians of patients Under Age 13

I, _____, confirm that I am the legal guardian of this patient and that I have read and agree to these terms, and I wish to communicate via email for the purposes of their clinical care.

Signature: _____ Date: _____