Shah Medical Clinic / Clinic for Genetic Medicine

Patient Request for Email Communication

PATIENT NAME_____

EMAIL ADDRESS:_____

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. To request that we communicate with you via email please complete the following form.

Please be advised that:

(1) This request applies to all healthcare providers and staff of Shah medical clinic/clinic for genetic medicine.

(2) the Shah medical clinic/Clinic for Genetic Medicine will not communicate health information that is specially protected under state and federal law (*e.g*., HIV/AIDS, substance abuse, mental health information) via email.

I understand and agree to the following:

- I certify the email address provided on this request is accurate, and that accept full responsibility for messages sent to or from this address.
- I received a copy of the important information about patient email form, and I have read and understand it.
- I understand and acknowledge the 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 communicated this way.
- 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 Shah medical clinic/clinic for genetic medicine and all individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email

PATIENT SIGNATURE_____ DATE:_____