ColumbiaDoctors

Patient Request for Email Communications

Patient Name: ______________________________ Date of Birth: ______________________________

Phone Number: ____________________________ 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 communicating via email. To request that this provider/program communicate with you via email you must complete this form and return it to your health care provider's office.

Please be advised that:

- **This request applies only to the healthcare provider or program that you indicate below. If you would like to request to communicate via email with another health care provider or program, you must complete a separate request for that office.**
- Columbia University Medical Center 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.
- You must provide your email address when registering for your visit with your provider
- It is recommended that you send a test email before corresponding via email.

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 communicated via email.
- I understand that all email communications may be forwarded to other providers for purposes of providing treatment to me.
- I agree to hold ColumbiaDoctors and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

______________________________________ ______________________________

Signature of patient **Date**

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Name of Physician or Program