Mount Sinai Doctors *Faculty Practice*

CONSENT FOR COMMUNICATION VIA E-MAIL (Provider-Patient)

I, _____, hereby consent to have my Mount Sinai Doctors Faculty Practice physicians communicate with me or members of his/her staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his/her office staff, or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

E-mail: _____

Patient Signature: _____ Date: _____

Personal Representative Name: _____

Personal Representative Authority: _____

Responsible Party Signature: _____