REQUEST AND CONSENT FOR PATIENT COMMUNICATIONS BY EMAIL

I, hereby authorize __________________________ (Name of Provider) to communicate with me by email regarding my diagnoses, examinations. tests and procedures, medications, treatment or therapy. assessments, illness, or injuries. I understand that communications over the Internet and/or using the email system are not encrypted and are inherently insecure. I also understand that there is no assurance of confidentiality of information when healthcare information is communicated this way. Nevertheless, I am requesting ("Request) that Maranacook Family Health Care communicate with me regarding my protected health information by email.

I understand that:

- Maranacook Family Health Care will not communicate to me or with me health information that is specially protected under state and federal law *(e.g.,* HIV/AIDS information, substance abuse treatment records information, mental health information) by email.
- Maranacook Family Health Care may cease communicating with me by email at any time.
- I have the right to cease communicating with Maranacook Family Health Care by email at any time.

Patient Name	DOB
Mailing Address	

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

Email

Please initial each blank and sign below:

_____ I certify the email address provided on this Request is accurate. and that I. or my personal representative on my behalf, accept full responsibility for messages sent by Maranacook Family Health Care to this address.

_____ I certify that I will not use email to communicate an urgent medical situation requiring an immediate response

_____ I understand and acknowledge that communications over the Internet and/or using the email system are not always encrypted and are inherently insecure, and that there is no assurance of confidentiality of information when communicated this way.

_____ I understand that all email communications I send and receive may be-forwarded to other providers. including providers not associated Maranacook Family Health Care. for purposes of treatment, payment or healthcare operations.

_____ I, agree to hold Maranacook Family Health Care Health harmless from any and all claims and liabilities arising from or related to any email communications authorized by me in executing this Request for Patient Communication by Email.

Patient Signature		Date
Parent/Guardian Signature	Parent/Guardian Name (Print)	Date
Witness Signature	Witness Name (Print)	Date