Chiropractic Neurology & Wellness Center

James M. Cartwright, DC, DACNB

PATIENT EMAIL CONSENT AGREEMENT

Patient Name: _____

Patient Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ Cell: _____

Email Address: _____

Practice Physician: Dr. James M. Cartwright, DC, DACNB

1. RISK OF USING EMAIL

Transmitting patient information by Email has a number of risks that patients should consider before using Email. These include, but are not limited to, the following risks:

a. **The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that email that contains protected health information be encrypted. Email sent from Dr. Cartwright and the Practice is not encrypted, so Email may not be secure.** Therefore it is possible that a third party may breach the confidentiality of such communications.
b. Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c. Email senders can easily misaddress an Email.
d. Email is easier to falsify than handwritten or signed documents.
e. Backup copies of Email may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to inspect Email transmitted through their systems.
g. Email can be intercepted, altered, forwarded, or used without authorization or detection.
h. Email can be used to introduce viruses into computer systems.
i. Practice server could go down and Email would not be received until the server is back on-line.
j. Email can be used as evidence in court.

2. CONDITIONS FOR THE USE OF EMAIL

The Practice cannot guarantee, but will use reasonable means to maintain security and confidentiality of Email information sent and received. The Practice and/or Physician are not liable for improper disclosure of confidential information that is not caused by the Practice and/or Physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a. **Email is not appropriate for urgent or emergency situations. The Practice and/or Physician cannot guarantee that any particular Email will be read and responded to within any particular period of time.**
b. **If the patient's Email requires or invites a response from the Practice and/or Physician, and the patient has not received a response within two (2) business days, it is the patient's responsibility to follow-up to determine whether the intended recipient received the Email and when the recipient will respond.**
c. Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via Email.
d. **All Email will usually be printed and filed in the patient's medical record.**
e. Office staff may receive and read your messages.
f. Practice will not forward patient identifiable Emails outside of the Practice without the patient's prior written consent, except as authorized or required by law.
g. The patient should not use Email for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. The Practice is not liable for breaches of confidentiality caused by the patient or any third party.
h. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
i. This consent will remain in effect until terminated in writing by either the patient or Practice.
j. In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by Email with the Practice.

3. INSTRUCTIONS

a. To communicate by Email, the patient shall:
b. Avoid use of his/her employer's computer.
c. Put the patient's name in the body of the Email.
d. Key in the topic (e.g., medical question, billing question) in the subject line.
e. Inform Practice of changes in his/her Email address.
f. Acknowledge any Email received from the Practice and/or Physician.
g. Take precautions to preserve the confidentiality of Email.
h. Protect his/her password or other means of access to Email.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of Email between the Practice, Physician and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patient by Email. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge **Chiropractic Neurology & Wellness Center** and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such Email.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____