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Patient Request for Email Communications

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

Communications over the Internet and/or using email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicating via email. In order to comply with your 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 to the healthcare provider that you indicate below. If you would like to request to communicate via email with another health care provider, you must complete a separate request for that office.
- Ear, Nose and Throat Associates of South Florida, PA, the office of Lee M. Mandel, M.D., 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 mail before corresponding via email.

I understand and agree to the following:

- I certify the email address 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 have read, understand it and am authorizing my requested information be sent to me via the email address I provided above.
- 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 Ear, Nose and Throat Associates of South Florida, PA, The Office of Lee M. Mandel, M.D. and individuals associated with it harmless from any and all claims and liabilities arising from or related to communication via email.

_____ _____
Signature of Patient Date

Name of Physician or Program: _____