EMAIL COMMUNICATION OF HEALTH INFORMATION
FACT SHEET AND CONSENT FORM - SEDALIA EYE ASSOCIATES, P.C.
(OPTIONAL – IF NOT INTERESTED, YOU DO NOT NEED TO SIGN THIS FORM)

As a patient of our office, you may request that we communicate with you via unencrypted electronic mail (email). This Fact Sheet will inform you of the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email, however, we reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your best interest.

Our staff will make every effort to promptly respond to your requests for information via email, however, if you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention.

Risks of using email to send protect health information (PHI) include, but are not limited to:

- **Risk of Unauthorized Access by a 3rd Party:** Emails may be accessed by someone you do not wish to know about your health information. For example, a computer shared with your family, an email address or access to email provided through your employer, or an unsecured connection such as public Wi-Fi increases the risk of someone else accessing your health information. Despite taking necessary precautions, email may be intercepted or altered in transmission by a computer hacker or computer virus.
- **Unique Difficulty in Verifying the Sender:** We will only send emails to the email address you provide, but it may be difficult to confirm that you are in fact the person sending the request for information from your email address.

Procedures

- Emails are not checked outside of normal business hours – this includes overnight, weekends, and holidays. Please call us if you have not received a response to your request either by email or phone by the end of business the following day. If at any time you change your email address or wish to discontinue email communications altogether, you must notify us immediately.

PATIENT CONSENT TO UNENCRYPTED EMAIL COMMUNICATIONS

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion. You also acknowledge that you have the choice to receive communications via other more secure means such as by telephone. By signing below, you agree to hold Sedalia Eye Associates, P.C. harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

Patient email address:_____
Patient Signature_____ Date of Birth:_____
Patient Name (printed)_____ Date:_____

If signed by someone other than the patient, state your relationship to the patient and a description of your authority to act on the patient's behalf.

_____