Consent for Email Communication of Patient Health Information

As a health care provider, providing access to your records in a secure manner while balancing ease of access is important to us. You have requested that we transmit a copy of your records, which may contain your Protected Health Information (PHI), via email. We are required by law to notify you that email is not a completely secure means of communication due to the fact that messages can be addressed to the wrong person or messages can be intercepted during transmission by a third party.

If you acknowledge the above risks and still would like for us to send your information via email, please print clearly, sign and complete the consent below. Please note – due to some email providers, certain size files may not be transmitted. In the event that there is trouble with transmission, we will mail a copy of your records to your home address.

Patient Information

Patient Name	
Date of Birth	
Street Address Including City, State, and ZIP Code	
Telephone	
Email Address	

I acknowledge the above risks and consent to the use of email to distribute my Protected Health Information.

Signature _____ *Signature of the Person Submitting this Form*

Name _____ *Name of the Person Submitting this Form (print)*

Date of Signature _____ *MM* _____ *DD* _____ *YY*

Practice Information

Business Name	Lexington-Waltham Dermatology Group, P.C.	Street Address Including City, State, and ZIP Code	57 Bedford St. Suite 201 Lexington, MA 02420
Telephone	781-862-2322	Fax	781-863-0927