KINGWOOD PSYCHIATRY

E-MAIL CONSENT FORM

Patient's Name Printed	Patient's Date of Birth	Email Address

Consenting Adults Name if Patient Under the age of 18

- **EMERGENCY PROBLEMS –** E-Mail should **never** be used for emergency problems**.** In the event of an emergency, call 911.
- **URGENT PROBLEMS –** E-Mail should **never** be used for urgent problems. In these cases, the patient should call 281-358-5701 or go to an urgent care or immediate care facility.
- **OUR OFFICE WILL NOT EMAIL YOU UNLESS IT IS IN RESPONSE TO YOUR EMAIL**

RISKS OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER

Dr. Athi Venkatesh shall be referred to throughout this consent as "Provider". However, this reference shall also include the members of the Provider's Staff.

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by email, however, has a number of risks that patients should consider before using e-mail to communicate with the Provider. These include, but are not limited to the following risks:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
b. E-mail can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify than handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
g. E-mail can be used as evidence in court.

CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of e-mail for the patient information.

ALTERNATE FORMS OF COMMUNICATION

I understand that I may also communicate with the provider via telephone or during a scheduled appointment and that the e-mail is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive medical information.

TYPES OF E-MAIL TRANSMISSIONS THAT PATINET AGREES TO SEND AND/OR RECEIVE

The types of information that can be communicated via e-mail with the Provider are appointment scheduling, appointment reminders, insurance information, financial information, lab results, and communications from the Doctor.

SECURITY MEASURES USED BY THE PROVIDER

As stated above, communicating via e-mail does come with privacy risk as stated above. While the Provider cannot guarantee total confidentiality, the Provider has and will use reasonable safeguards to protect your healthcare information as required by law. The security measures taken by the Provider include password protected screen savers, policies and procedures, staff training requirements.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the Provider may impose to communicate with patients by email. Any questions I may have had were answered.

Patient Signature or Legal Guardian	Date