PR7947

Charleston Area Medical Center
Charleston, West Virginia

REQUEST FOR ALTERNATIVE COMMUNICATION OF PROTECTED HEALTH INFORMATION VIA EMAIL

Today's Date: _____

Patient Name:_____

Medical Record Number (if known) _____

Birth Date _____ Last 4 Digits of SSN _____

Address _____

Phone Number (Home)_____ (Work)_____

I hereby request and authorize Charleston Area Medical Center, Inc., to communicate Protected Health Information ["PHI"] with me via Internet Electronic Mail ["email"] using any email address that I provide to CAMC for that purpose.

The email address for which I am currently requesting this communication is as follows:

_____

The physicians and other persons with whom I currently wish to communicate via email (are) as follows:

_____

The Protected Health Information to be communicated to me by email includes the following (provide specific description, including dates of service when applicable):

_____

I acknowledge and accept the increased risk of disclosure of PHI inherent to email. While interception, alteration, or destruction of any particular email message is unlikely, the risk is probably greater than communications via telephone or in person. I hold CAMC, its agents representatives, and physicians harmless for any interception, alteration, or destruction of any email message sent or received to or from CAMC.

I acknowledge and accept that physicians may have office staff or covering physicians assist in reading, responding to, or otherwise handling their emails.

I acknowledge and accept that CAMC or my physician may not permit certain types of transaction [communications] to be handled via email.

I agree to put the category of transaction [type of communication] in the subject line of the message for filtering purposes, such as, for example, a prescription, appointment, medical advice, or billing question, etc.

I agree to put my name and patient identification number in the body of the message to help ensure positive identification.

I acknowledge and accept that copies of the email messages exchanged with my physician may be placed into, and made part of, my CAMC medical record chart, as well as the medical chart of the physician, if different.

I acknowledge and accept that CAMC or my physician may choose to discontinue the use of email for communicating PHI with me. I understand that I will be notified of any decision to discontinue email communications.

If you are not the patient, please fill in the following:

Your name _____ Relationship to the patient _____

Address (if different than above)_____

Phone Number (Home) _____ (Work) _____

By giving my signature in the space provided below, I am requesting that CAMC communicate PHI with me via email, and accept the terms and conditions listed above.

SIGNATURE: **DATE:**