ColumbiaDoctors
The Physicians and Surgeons of Columbia University

Health Information Management (HIM)
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Patient Request for Email Communications

Patient Name:_____ Date of Birth: _____

Phone Number:_____ Email Address:_____

I request to communicate with my provider via unencrypted email. Completing this form is needed to document your request and permit a provider/program to communicate with you via unencrypted email. Send completed form to your provider's/programs office.

I understand that communications over the Internet or use of an email system may not be secure. There is no assurance of confidentiality when communicating via email.

Please be advised that:

- **This request applies only to the healthcare provider or program stated indicate below. If you would like to request to communicate via unencrypted email with another health care provider or program, a separate form is required.**
- An email address must be provided
- A test email is recommended before corresponding via email.

I understand and agree to the following:

- The email address provided 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.
- I understand and acknowledge that communications over the internet or using unencrypted email may not be secure and there is no assurance of confidentiality of information communicated via email.
- I understand that email communications may be forwarded to other providers for purposes of providing treatment to me.
- I agree to hold ColumbiaDoctors and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

_____ _____

Signature of Patient **Date**

_____

Name of Physician/Program