Trillium Health Partners

PATIENT CONSENT FOR EMAIL COMMUNICATION
RELEASE OF INFORMATION

I, _____ *(name of Patient/Substitute Decision Maker)* wish to receive records from the hospital through email. I understand that these email messages are encrypted on the hospital email system. However, the hospital cannot guarantee the security of messages that I receive and send from my health care provider. Email is convenient but there is also a risk that information exchanged can be disclosed to a third party. It can be intercepted, forwarded, stored, even changed, or accessed by third party or email providers without anyone's knowledge or consent. This also applies to the use of email.

I agree not to use email to communicate emergency or urgent health matters since email messages can be delayed for technical reasons. I understand that my care provider may make decisions about my treatment based on information I provide and that this information will also form part of my health record if it is relevant to my care.

I acknowledge that at any time, I or the hospital can decide that we no longer wish to communicate through email. If I decide to stop communicating through email, I agree to inform the hospital at the earliest opportunity. If the hospital cannot continue email communication with me, the hospital will notify me at the earliest opportunity.

By signing this Consent, I confirm I have read and agree to these terms.

_____	_____
Date Signed (YYYY/MM/DD)	Email Address
_____	_____
Name of Patient/Substitute Decision Maker	Signature of Patient/Substitute Decision Maker
_____	_____
Name of Translator (if required)	Signature of Translator (if required)