Canyon Medical Center Email Consent Form

(please read carefully, sign and return)

Communications over the Internet or using traditional e-mail systems are not encrypted and are inherently insecure. Confidentiality of information transmitted this way cannot be assured. If you wish to communicate with our office using a non-secure Web messaging system, you must read and complete this form.

Please give us the following information:

Name of parent/guardian/patient_____
Date of Birth:_____
Phone Number_____
Address_____

E-mail is intended to facilitate both of us in managing your health care needs. It is not intended for the solicitation of personal information, transmission of jokes or other "non-healthcare" information.

E-mail is not intended to be used to communicate information that is considered URGENT or EMERGENT. If the concerns you have are of an Urgent or
Emergent nature please call our office at 614-864-6010 and do not email.

E-mail will be checked Monday thru Friday from 8-5PM. If the office is closed for a holiday email will be checked when the office re-opens.

If you are E-mailing for a prescription refill request we will need the following information to ensure we fill the medication accurately and for the correct person. Prescription refill requests should not take longer than 48 hours to process.

a. Patient Name
b. Date of Birth
c. Name of drug; its dosage and number of times per day you take the medication
d. Name and phone number of pharmacy; or
e. please state if it is for a mail-in pharmacy

We will make every attempt to answer emails every 2 hours. If your email is of a routine nature and can wait till the end of the day it will be answered at the end of the day.

I understand and acknowledge that communications over the Internet or using general, non-secure e-mail systems are not encrypted and are inherently insecure. I understand that there is no assurance of confidentiality of

information when communicating this way. I understand that all e-mail sent to Canyon Medical Center may be forwarded to other health care providers for purposes of providing treatment. I agree to hold Canyon Medical Center and all individuals associated with it harmless from any and all claims and liabilities arising from, or related to, this service. Canyon Medical Center reserves the right to restrict e-mail communications to those patients and families who adhere to the guidelines outlined above.

I have read the above and agree to all terms and conditions. I acknowledge that I may withdraw my consent to use this service at any time by contacting Canyon Medical Center by phone, fax, e-mail or letter.

Signature_____ Date_____

Print Name_____