#8.

Patient Communication Consent Form

From time to time, we may need to communicate with you and to preserve your privacy, we would like for you to indicate your preferred method for us to communicate to you. Examples of such information to be communicated include appointment dates, appointment reminders, appointment follow-up, test results, billing questions, and other information clinical in nature.

In the event that no one is available to answer your phone, we request your permission to leave certain types of information on your answering machine, voicemail, or email. Please fill out the following and then indicate your preference by checking Yes □ / No □ of the boxes below;

Name			
Add:		City/St/Zip	
Home		Cell	
E-mail		E-mail	

I give permission to Mid Cities Psychiatry personnel to leave the following forms of information pertaining to me on answering machine, voice-mail or e-mails listed below.

communication	cell #	home #	e-mail
appointment date/reminders	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
appointment follow-up	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
test results	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
information clinical in nature	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
billing questions	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐

This consent may be revoked at any time after written notification is received, except to the extent that action has been taken.

Share Your Experience With Us

Our #1 priority is your satisfaction. Your reviews are an important part of our practice. We'll send you an e-mail asking you to share your experience with us. Please note only your first name and last initial will appear on your review. Your email will not appear on the review and we will never share it with third parties.

1. RISK OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:

a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

b) Email senders can easily misaddress an email.

c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.

d) Employers and on-line services have a right to inspect email transmitted through their systems.

e) Email can be intercepted, altered, forwarded, or used without authorization or detection.

f) Email can be used to introduce viruses into computer systems.

g) Email can be used as evidence in court.

h) Emails may not be secure, including at USC, and therefore it is possible that the confidentiality of such communications may be breached by a third party

2. CONDITIONS FOR THE USE OF EMAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular period of time.

b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.

c) All email will usually be printed and filed in the patient's medical record.

d) Office staff may receive and read your messages.

e) Provider will not forward patient identifiable emails outside of Mid Cities Psychiatry without the patient's prior written consent, except as authorized or required by law.

f) The patient should not use email for communication regarding sensitive medical information.

g) Provider is not liable for breaches of confidentiality caused by the patient or any third party.

h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted

3. INSTRUCTIONS

To communicate by email, the patient shall:

a) Avoid use of his/her employer's computer.

b) Put the patient's name in the body of the email.

c) Key in the topic (e.g., medical question, billing question) in the subject line.

d) Inform Provider of changes in his/her email address.

e) Acknowledge any email received from the Provider.

f) Take precautions to preserve the confidentiality of email

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I have any questions I may inquire with my treating physician or the Mid Cities Psychiatry Privacy Officer.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date