MID DAKOTA CLINIC | MDC
The doctors you know and trust.℠

Email Communication Consent Form

The risk of using email

For the convenience of our patients, Mid Dakota Clinic would like to offer the opportunity to communicate certain types of patient information by email. Transmitting patient information using email poses several risks and the patient should not agree to communicate with their provider via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

- The privacy and security of email communication **cannot** be guaranteed.
- Email senders can misaddress, resulting in unintended recipients viewing the message.
- Employers and online services may have a legal right to inspect and retain emails that pass through their system.

Conditions of using email

By choosing to send Protected Health Information (PHI) to a provider at Mid Dakota Clinic, the patient agrees to the following conditions:

- Emails will only be accepted in circumstances where data or examination cannot be reasonably obtained in any other way.
- Any other communication, like appointment changes, questions for the provider, billing questions, etc., must be done by traditional means, like phone or portal message.
- Emails from the patient will be made part of the patient's medical record.
- Anyone otherwise authorized to access the patient's medical record will also have access to the content of any emails received from that patient.
- In light of our commitment to the privacy and security of the patient's health information, **the provider will never respond via email**. The patient will receive a response by phone call or secure patient portal, instead.

Patient acknowledgment and agreement

I acknowledge that I have read and fully understand this form. I understand the risks associated with email communication between myself and Mid Dakota Clinic, and consent to the conditions outlined herein. I acknowledge Mid Dakota Clinic's right to withdraw the option of communicating through email at any time.

Date: _____

Patient Name (please print): _____

Patient Signature: _____