Employee Communications Waiver

I, ____________________ acknowledge that communications with the Physician using email, fax, texting, and cell phone are not guaranteed secure or confidential methods of communications. As such, I expressly waive the Physician's obligation to guarantee confidentiality with respect to correspondence using such means of communication. Patient acknowledges that all such communications may become a part of your medical records. By Providing Patient's email address below, I authorize the Practice and its physicians or employees to communicate with the patient by e-mail regarding the Patient's "protected health information" ("PHI") (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and it's implementing regulations). I further acknowledge:

- Email is not necessarily a secure medium for sending or receiving PHI, and there is always a possibility that a third party may gain access;

- Although the Practice and the Physician and employees will make all reasonable effort to keep email communications confidential and secure, there is no guarantee of the absolute confidentiality of email communications;

- At the discretion of the Physician, email communications may be made part of the permanent medical record

- I understand and agrees that email is not an appropriate means of communication of emergencies or other time sensitive issue or for inquiries regarding sensitive information.

- If I do not receive a response to an email message within one day, the Patient agrees to use another means of communication to contact the Physician. Neither the Practice nor the Physician will be liable to patient for any loss, cost, injury, or expense caused by, or resulting from a delay in responding to patient because of technical failures.

Signed ____ Date: _______________

Employee Contact Information

Employer: ______________________________

Patient Name:__________________________________Date of Birth:_______________

Address:________________________________ City _______________ Zip Code_______

Email:____

Home Phone:___________________Cell Phone:_____________________

Emergency Contact:_____________________________________ Phone:_____________

Employee Family - Only fill this part out if you are adding any member of your family to this plan.

Spouse/Significate other Contact Information

Name:_________________________Date of Birth________________

Email:____Cell Phone:____________________

Minor Child

Name_______________________________________Date of Birth____________________

Name_______________________________________Date of Birth____________________

Name_______________________________________Date of Birth____________________

Name_______________________________________Date of Birth____________________