

## E-MAIL COMMUNICATIONS WITH PATIENT AGREEMENT

NAME IN FULL OF PATIENT OR SUBSTITUTE DECISION MAKER					
theRELATIONSHIP TO PATIENT, IF SUBSTITUTE DECISION MAKE	R NAME OF PATIENT				
have discussed communicating with,	NAME OF HEALTH CARE PROVIDER via e-mail.				
I acknowledge and agree that:					
<ul> <li>E-mail is not a secure or confidential form of communication. As the message leaves St. Joseph's Health Care (SJHC), it is sent across the Internet, where it could be intercepted and read. For this reason, SJHC cannot guarantee the security of messages that are sent to and by me</li> </ul>					
<ul> <li>My care provider will not use e-mail to commune</li> </ul>	nicate sensitive personal or health information				
Specific issues that will <b>not</b> be discussed via e	-mail include:				
E-mail will <b>not</b> be used to communicate emerg	ency or urgent health matters, as I understand that:				
<ul> <li>e-mail messages can be delayed for both t practitioner and</li> </ul>	technical reasons and issues relating to the availability of the health				
<ul> <li>my condition or the emergency situation cannot be adequately assessed via e-mail</li> </ul>					
<ul> <li>Clinical decisions about treatment or care may be made on the basis of health information conveyed in e-mail messages</li> </ul>					
<ul> <li>A printout of any e-mail communication related to treatment or care will be stored in my/the patient's hospital record</li> </ul>					
	il at any time if the conditions in this agreement are not adhered to. DM or health care provider as applicable, if this form of				
E-mail may be used for:  Conveying routine test results  Scheduling appointments  Certain counseling, e.g. nutritional  Other reasons as agreed upon by myself and re	my health care provider:				
Date:	SIGNATURE OF PATIENT OR SUBSTITUTE DECISION PROVIDER				
	PRINTED NAME OF PATIENT OR SUBSTITUTE DECISION PROVIDER				
Date:	SIGNATURE OF HEALTH CARE PROVIDER				
	PRINTED NAME OF HEALTH CARE PROVIDER				

E-mail Communications with	Patient Agreement	(continued)
E-mail Communications with	Patient Adreement	(continued)

Patient's Name:				

Other individu	uals to receive and	send e-mail on be	ehalf of health care provider:
Date:			
Date.	(YYYY/MM/DD)		PRINTED NAME OF INDIVIDUAL
			SIGNATURE OF INDIVIDUAL
Date:	(YYYY/MM/DD)		PRINTED NAME OF INDIVIDUAL
			SIGNATURE OF INDIVIDUAL
Date:	(YYYY/MM/DD)		PRINTED NAME OF INDIVIDUAL
	(TTTT/MIM/DD)		PRINTED NAME OF INDIVIDUAL
			SIGNATURE OF INDIVIDUAL
Date:	(YYYY/MM/DD)		PRINTED NAME OF INDIVIDUAL
			SIGNATURE OF INDIVIDUAL
I			ONE CONSENT  have spoken with,
	PRINTED NAME OF	FHEALTH CARE PROVIDER O	DBTAINING INFORMED CONSENT  by telephone as that person
	NAME OF PA	TIENT OR SUBSTITUTE DECIS	
			tten consent form and communication of the consent form by nably available. I have obtained informed consent over the
telephone for e	e-mail communication	n with.	·
			NAME OF PATIENT OR SUBSTITUTE DECISION MAKER
Date and Time	e of Telephone Call:		
(YYYY//	/MM/DD)	(HH:MM)	SIGNATURE OF HEALTH CARE PRACTITIONER
	SIGNATURE OF HEALTH PRACTITIONER \	WHO HAS WITNESSED THE FU	PRINTED NAME ULL CONVERSATION WITH RESPECT TO INFORMED CONSENT