**Laura Hild, RMT**

**Electronic Documents Policy** **Agreement**

Dear patient:

 I can communicate with you or others using email but you need to understand the risks of using email:

 The security of email messages is not guaranteed. Messages sent to, or from, me may be seen or read by others. Emails can be accidentally forwarded, and may exist indefinitely. For this reason, it is recommended that you do not use email to discuss information you think is sensitive. If you decide to use email, please tell me if there are certain types of information that you do not want to discuss by email.

 Do not use email messages in an emergency because email messages can be delayed or I may not be able to read it soon enough.

 I will discuss with you which types of conversations you are comfortable having over email (e.g. scheduling appointments).

 I may make decisions about your care based on information you provide in email.

 If an email has information that is important to your care, it will be copied or summarized into your record - much like a conversation.

 Email may be forwarded or read by other staff who may need the information to provide your care.

This Consent Form lets us know when we may use email to communicate with you or others. If at any time you decide that you no longer want to communicate by email, please tell me as soon as possible.

**By signing below, you accept the risks of using email and agree to the following:**

**Laura Hild, RMT may:**

 **Communicate with me by email at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **OR/INSTEAD**

**Communicate with the person named below by email:**

 **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Communicate with the following outside care providers by email:**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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*Signature of Patient/Substitute Decision Maker Date*