New England College of Optometry

CENTER FOR EYE CARE

AUTHORIZATION TO EMAIL PROTECTED HEALTH INFORMATION

Patients and/or personal representatives who want to communicate with their health care providers by email are strongly encouraged to consider all of the following points before signing this Authorization to Email Protected Health Information:

1. Email is not a secure means of communication and it can be forwarded, intercepted, printed and stored by others.
2. Email communication is a convenience and is not appropriate for emergencies or time-sensitive issues**.** As email may not be checked regularly, emergent or urgent issues should be discussed by phone calls or during office visits.
3. Highly sensitive or personal information should only be communicated by email at the patient's discretion (i.e., HIV status, mental illness, chemical dependency, and workers compensation claims).
4. Employers, including certain departments such as Human Resources and Information Technology, generally have the right to access any email received or sent by a person at work.
5. Staff other than the health care provider to whom the email is addressed may read and process email.
6. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
7. Email message content must include (1) the subject of the message in the subject line (i.e., prescription refill, appointment request, etc.) and (2) clear patient identification, including patient name, telephone number and date of birth or patient identification number (if known) in the body of the message (not the subject line).
8. NECO does not encourage email communications for health information and it will not be liable for information lost or misdirected due to technical errors or failures.

If this form is completed and signed by the patient, then unsecure email communication about the patient's medical care and treatment may be used to transmit information between the patient and NECO Center for Eye Care.

Authorize email communication

☐ I authorize NECO Center for Eye Care to email me with questions regarding my account status

☐ I authorize the NECO Center for Eye Care providers and staff to email me regarding the course of my medical care, treatment and diagnostic test results, **excluding** information concerning mental health, substance abuse, and sexually transmitted disease.

☐ I authorize the NECO Center for Eye Care providers and staff to email me regarding the course of my medical care, treatment and diagnostic test results, **including** information concerning mental health, substance abuse, and sexually transmitted disease.

Patient/representative's email address (*please print*): _____

*Signature required on next page**

Patient ID (*for administrative purposes only*): _____

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Change email address

☐ I am changing the email address to be used for communications with NECO Center for Eye Care.

New email address (*please print*): _____

Signature required

Discontinue email communication

☐ I no longer wish to communicate via email. **Signature required **

- I understand that any email transmission between my provider and me/the patient will become part of my medical record. These email transmissions may be disclosed in accordance with future authorizations.
- I understand that I have the right to revoke this Authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information. I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this authorization.
- I understand that this Authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, membership or eligibility for benefits if I refuse to sign this Authorization.

I have read and understand this Authorization to Email Protected Health Information and agree that email messages may include protected health information about me/the patient, whenever necessary.

_____ _____

Patient/representative's signature Today's date

_____ _____

Patient's printed name Date of birth

_____ _____

Patient representative's name Relation

Please note that this Authorization is not valid unless completed in full. This Authorization will not expire unless revoked in writing.

Patient ID (*for administrative purposes only*): _____