Trillium Health Partners
Better Together

RESET

Last Name: _____ First Name: _____

Date of Birth (DD/MM/YYYY): _____/_____/_____

Health card #: _____

MRN #: _____

CSN #: _____

Affix patient encounter label here/complete all fields if label not available.

PATIENT CONSENT FOR EMAIL COMMUNICATION

I, (Last) _____ (First) _____ *(name of Patient/Substitute Decision Maker)* wish to communicate with my care-provider using email.

I understand that the hospital cannot guarantee the security of email messages that I send to or receive from my care-provider.

I agree not to use email to communicate emergency or urgent health matters since the delivery of email messages may be delayed.

I understand that my care-provider may make decisions about my treatment based on information I provide through email and that this information may form part of my health record.

I understand that I can stop using email for this purpose at any time, and I will inform my care-provider in a timely way if I choose to stop.

I understand that my care-provider can stop using email for this purpose at any time, and s/he will inform me in writing or notify me about this at the time of my next appointment.

By signing this Consent, I confirm I have read and agree to these terms.

_____
Date Signed (DD/MM/YYYY)

_____ _____ _____
Last Name **First Name** **Witness Signature**
Name of Patient/Substitute Decision Maker

_____ _____
Signature of Patient/Substitute Decision Maker **Patient/SDM email address**

THIS DOCUMENT IS TO BE RETAINED WITHIN THE PATIENT CHART

8770 D HR (May/2022)