

**The University of North Carolina at Greensboro (UNCG)
Patient/Client – Provider E-mail Communication Form¹**

I request that staff members of (the Provider) at the University of North Carolina at Greensboro (UNCG) use electronic mail (e-mail) to communicate clinical information to me pertaining to health care services that I have received or may receive in the future. I acknowledge and understand that e-mail communication may contain my personal and private medical information including, but not limited to, my name, address, date of birth, types and dates of health care services received, medication, insurance coverage information, and/or test results. I understand that, although the Provider and UNCG may attempt to protect the privacy of the contents of email sent to me and will take reasonable measures to protect my privacy, ***the e-mail messages sent to me are not encrypted and travel over the Internet. As a result, there is a risk that the e-mail will be intercepted and read by unauthorized third parties.*** In requesting the Provider to send me e-mail, I assume this risk.

I also acknowledge and understand the following as it relates to these e-mail communications:

1. I will never use E-mail to contact the Provider about emergency medical or mental health matters.
2. I will do my best to not use e-mail for discussion of sensitive or highly confidential issues; for example, mental health, substance abuse, communicable disease, etc.
3. Employees of UNCG and the Provider such as nurses, consulting physicians and other health care staff members that are permitted access to my medical records may also have access to my e-mail address and the contents of emails between the Provider and me.
4. I, and not the Provider or UNCG, am responsible for the security of e-mail communications sent from or stored on my computer.
5. My decision to request that the Provider communicate with me by e-mail is voluntary, and treatment is not conditioned upon my election to do so.
6. The Provider or I may stop e-mail communication at any time for any reason. The Provider retains the discretion to deny this request and/or to communicate with me by other means.
7. I agree to notify the Provider when my e-mail address changes.
8. I will not hold the Provider, UNCG or their employees responsible for damages resulting from the use of e-mail or the failure of any information systems used to facilitate e-mail communication.

Please sign separate ***Electronic Communication Permissions*** form available:

Keep in the Patient's Medical Record [Created 3/18/10, non-substantive rev. 3/18/19; some portions taken from University of Chicago Form] ¹ Electronic version of form available from <https://provost.uncg.edu/policies-procedures-forms/hipaa/> .