The University of Chicago Medical Center (UCMC)
Patient – Provider E-mail Communication Form

I allow _____ (the Provider) to use electronic mail (e-mail) to communicate clinical information to me pertaining to health care services that I have received. 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 the UCMC may attempt to protect the privacy of the contents of e-mail 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 allowing the Provider to send me e-mail, I assume this risk.

I also acknowledge and understand the following as it relates to this e-mail communication:

1. E-mail is not appropriate for conveying information relating to emergency medical matters.
2. If an e-mail has not been answered, I may make an appointment to see/speak with the health care provider to discuss the e-mail message.
3. I will not use e-mail for discussion of sensitive or highly confidential issues; for example, mental health issues, etc.
4. Employees of UCMC other than the Provider may have access to my e-mail address and e-mail content, such as triage nurses, consulting physicians, and other health care providers that are permitted access to my medical records.
5. I, and not the Provider or UCMC, am responsible for the security of e-mail communications sent from or stored on my computer.
6. My decision to allow the Provider to communicate with me by e-mail is voluntary, and that treatment is not conditioned upon my election to do so.
7. I may complete separate Forms with every UCMC provider I wish to communicate with by e-mail.
8. The Provider or I may stop e-mail communication at any time for any reason.
9. I agree to notify the Provider when my e-mail address changes.
10. I will not hold the Provider or UCMC responsible for damages resulting from their use of e-mail or the failure of any UCMC information systems used to facilitate the e-mail communication.

The Provider may send medical information to my e-mail address, which is: ***(Please complete below)***

The Provider may communicate via email to the designated individual listed below.

Name (Print):	**Relationship to Patient:**	**E-mail Address:**

Patient Name (Print):	***Patient/Patient Representative Signature:***
Date:	***MRN (to be completed by UCMC):***