



CONSENT FOR COMMUNICATION VIA EMAIL/TEXT MESSAGE

(Provider-Patient)

I, _____, hereby consent to have my physician at Russak Dermatology Clinic communicate with me or members of their staff, where appropriate or other physicians, nurse practitioners and pharmacists via email/text regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail/text is not a confidential method of communication. I further understand that there is a risk that e-mail/text communications between my physician and myself or members of my physician’s office staff, or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail/text. I understand that for sensitive medical information, email/text should be concise. If there is a problem that is complex or sensitive to discuss via email/text, I should schedule an office visit.

I consent to communication via: Email Text Message Both I do not consent

Patient Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between RDC staff and myself, and consent to the conditions and instructions outlined.

Patient first and last name: _____

Today's date: _____

Patient signature: _____