

Pulmonary & Sleep Consultants, LLC
Serenity Sleep Institute



“Breathe Easier, Sleep Better”
www.pscssi.com



Patient Consent for Use of Email Communications

To better serve our patients, this office has established an email address for some forms of communication.

I, _____, may want to communicate with Pulmonary & Sleep Consultants, LLC (PSC) via email.

My email address is: _____.

_____ I understand the risks of communicating by email, in particular, the privacy risks. I understand that PSC cannot guarantee the security and confidentiality of email communication. PSC will not be responsible for messages that are not received or delivered due to mechanical or technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration.

_____ I understand that I may communicate with PSC by telephone or during scheduled office visits and that email is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or sensitive medical information. Medication refills will not be addressed by emails. Medication refills should be requested during regular follow-up appointments.

_____ I understand that either I or PSC may stop using email as a means of communication upon my written request. I understand that I may revoke this consent at any time by advising PSC in writing. My revocation of consent will not affect my ability to obtain care.

I have read and understand this form. I have had the opportunity to ask questions and my questions, if any, have been answered to my satisfaction. I understand and agree with the information contained on this form and give my consent for email communication to and from Pulmonary & Sleep Consultants, LLC.

Communications relating to diagnosis and treatment will be filed in your medical record.

I understand and agree to the above email policy.

Patient's signature

Date