REGENCY HEALING MEDICAL CLINIC
Healing And Preserving Our Community

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# Consent to E-mail Protected Health Information

It is the policy of the Practice to require written consent prior to communicating over the Internet with patients. Communications over the Internet and/or using the e-mail system are not encrypted and are inherently insecure. There is no assurance of confidentiality of information when communicated this way. Nevertheless, patients may request that the Practice communicate with them via e-mail. To do so, patients must provide a written consent to e-mail protected health information (PHI). (See also policy 8.06 E-mail Communication with Patients.)

PROCEDURES

1. The Practice employee receiving the request from the patient to transmit PHI via e-mail informs the patient that this method is not secure and could be intercepted during transmission.
2. If the patient agrees to have PHI transmitted via e-mail, the patient is asked to provide his or her e-mail address so that a test message can be sent to assure the accuracy of the e-mail address.
3. The patient is required to sign a release of information specifically related to the method of transmission (see the Request to E-mail Protected Health Information form on the next page).
4. When the employee transmits the test message, the employee sends it with a return receipt to assure that the message was received.
5. Upon receipt of the reply and the signed release, the employee may reply with the requested information.
6. The patient's account is noted of the request and response and the patient's request and consent are filed in the patient's medical record and/or in an electronic file for future reference.

## REQUEST TO E-MAIL PROTECTED HEALTH INFORMATION

Please be advised that:

(1) This Request applies only to Regency Healing Medical Clinic. If you would like to request to communicate via e-mail with another healthcare provider or office, you must complete a separate request for that office.

(2) The Practice does not communicate health information that is specially protected under state and federal law (e.g., HIV/AIDS information, substance abuse treatment records information, mental health information) via e-mail even if the Practice agrees to communicate with you via e-mail. The Practice also does not transfer medical records via e-mail; those must be requested using the practice's authorization to release medical records processes and procedures.

(3) Your request is not effective until you receive and respond appropriately to a test e-mail message from the Practice. Please select the test question you want to use below, and provide us with your answer.

Please provide the following information:
Patient name:_____ Date of birth: _____
Phone #: _____
Address: _____
Please specify the e-mail address to which communications should be addressed:
_____
Please specify the healthcare provider from which you are requesting e-mail communications:

_____

Please select the question you want to use (by checking one of the boxes below) for your test e-mail and provide your answer.

__ The last four digits of my Social Security number: _____
__ My mother's maiden name: _____
__ My middle name: _____
__ The street number of my residence: _____

Please initial each blank above and sign below:

Patient signature: _____ Date: _____