SHERBONDY'S
PSYCHIATRIC SOLUTIONS

**225 Adley Way – Greenville, SC 29607**

# ***Email Consent***

Patient Name: _____ E-mail Address: _____

Date of Birth: _____ Phone Number: _____

**Sherbondy's Psychiatric Solutions offers our patients the opportunity to communicate by e-mail. This form provides information about the risks of e-mail communication. It also will be used to document your consent for us to communicate with you by e-mail.**

**RISKS** – **Communication by e-mail has several risks which include, but are not limited to, the following:**

E-mail can be circulated, forwarded and stored in paper and electronic files, Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy, E-mail can be received by unintended recipients, E-mail senders can easily type in the wrong e-mail address, E-mail can be used to introduce viruses into computer system.

**HOW WE WILL US E-MAIL:**

**(1).** We will limit e-mail correspondence to established patients who are adults 18 years or older, or the legal representatives of established patients. **(2).** We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as: (a). Questions about prescription refills, prior authorizations (b). Routine follow-up questions (c). Appointment scheduling, billing or payment questions or correspondence. **(3).** All e-mails to or from you will be made a part of your medical record. You will have the same rights of access to such e-mails as you do to the remainder of your medical file. **(4).** Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling. **(5).** We will not disclose your e-mail to researches or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

**IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL…CALL 911.** Also, do not use e-mail for **urgent problems.** If you have an urgent problem, call our office number or go to an urgent care facility.

**GUIDELINES FOR E-MAIL COMMUNICATION:**

**(1).** Include the general topic of the message in the "subject" line of your e-mail. For example, "advice," "prescription," "appointment" or "billing question." **(2).** The e-mail message should not be time sensitive. While we try to respond to e-mail messages daily, it may take up to two 2 working days for us to respond to your message. Urgent messages or needs should be relayed to us using regular telephone communication. **(3).** Include your name and phone number in the body of the message**. (4).** Review your message to make sure it is clear and that all relevant information is included before sending. **(5).** Send us and e-mail confirming receipt of our message after you have received and read an e-mail message from us. **(6).** If your e-mail requires a response form us, and you have not heard back from us within two 2 working days, call our office to follow-up to determine if we received your e-mail. **(7).** Take precautions to protect the confidentiality of e-mail, such as safeguarding your computer password and using screen savers. **(8).** Inform us of changes in your e-mail address.

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**CONSENT**: _____, is [] an established patient of Sherbondy's Psychiatric
***(print name patient or legal representative)***

Solutions, [] the legal representative of an established patient, _____/____/_____
***(print patient name and date of birth)***

**I** may want to communicate with Sherbondy's Psychiatric Solutions and the office staff by e-mail. I under stand the risks of communicating by e-mail, the privacy risks explained in this form. I understand that (Sherbondy's Psychiatric Solutions) cannot guarantee the security and confidentiality of e-mail communication. Sherbondy's Psychiatric Solutions will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

**I** understand that I may also communicate with Sherbondy's Psychiatric Solutions by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.

**I** understand that either I or Sherbondy's Psychiatric Solutions may stop using e-mail as a means of communication upon my written request.

**I** understand that I may revoke this consent at any time by so Sherbondy's Psychiatric Solutions in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

**I** have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from Sherbondy's Psychiatric Solutions.

Signature: _____ Date: _____ Witness Initials: _____ (Office Staff)