Primary Care Partners
Affiliated with
Atlantic Health System

PATIENT AGREEMENT FOR E-MAIL COMMUNICATIONS ("E-MAIL AGREEMENT")

I _____ the
Full Name of Patient or Personal Representative

_____ of _____
Relationship to Patient, if Personal Representative — Name of Patient

have discussed communicating with, the Staff at Skylands Pediatrics via email.
Name of Health Care Provider

I acknowledge and agree that:

- E-mail is not a secure or confidential form of communication. As the message leaves Atlantic Health System ("AHS"), it is sent across the internet, where it could be intercepted and read. For this reason, AHS cannot guarantee the security of messages that are sent to and by me
- My care provider will not use e-mail to communicate sensitive personal or health information
- Specific issues that will **not** be discussed via e-mail include:

_____

- E-mail will not be used to communicate emergency or urgent health matters, as I understand that:
  - E-mail messages can be delayed for both technical reasons and issues relating to the availability of the health practitioner and
  - My condition or the emergency situation cannot be adequately assessed via e-mail
- Clinical decisions about treatment or care may be made on the basis of health information conveyed in e-mail messages
- A print-out of any e-mail communication related to treatment or care will be stored in my/the patient's hospital record
- Either party may stop communication via e-mail at any time of the conditions in this agreement are not adhered to. Notice must be given in writing to the patient/legal representative or health care provider as applicable, if this form of communication is to stop.
- E-mail may be used for:
  - Conveying routine test results
  - Scheduling appointments
  - Certain counseling, e.g. nutritional
  - Other reasons as agreed upon by myself and my health care provider:

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Composing E-mail Messages: When composing e-mail messages to providers, patient shall:

(a) write concisely
(b) include patient's full name and patient identification number in the subject line, and a brief description of the nature of the request (e.g."prescription refill," "medical advice," "billing question")
(c) when requested by provider, send reply to the provider to acknowledge receipt and review of e-mail message from provider

_____ _____ _____
Signature of Patient or Personal Representative* — Date — Time

_____ _____
Printed Name of Personal Representative — Relationship (if not Patient)

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (e.g. Court-appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen. For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an amendment request signed by the named individual. If the estate has not been probated, a completed amendment request, death certificate and personal representative form all MUST be submitted.

_____ _____ _____
Signature of Health Care Provider — Date — Time

_____
Printed Name of Health Care Provider