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:

_____

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

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Authorization for RELEASE of Information

This form is to be used for releasing information to other physicians, facilities, schools, and outside agencies. In addition, this form is to be used when a patient wants their records to be transferred.

I do hereby consent to and authorize Primary Care Partners Skylands Pediatrics (Name of Care Center) to disclose to the facility/person(s) named, information from my medical records relating to my treatment. This release is to be **limited** to the specified reports within the **specified dates of treatment** I have indicated below. I understand that this consent shall operate as a complete release of liability to Primary Care Partners, the Care Center and to its employees for the release of information as specified below.

PURPOSE _____ DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

TREATMENT DATES NEEDED: _____ TO _____ (specify month/year)

SPECIFIED REPORTS/EDUCATION INFORMATION: *(Check appropriate boxes)*

[ ] Abstract: face sheet, history & physical, discharge summary, all medical tests, operative section
[ ] All Medical Tests: labs, ECG, x-ray, operative section
[ ] Immunization/Vaccine Information only
[ ] Complete copy
[ ] HIV/AIDS treatment records *(if your information contains HIV/AIDS related information you must check this box)*
[ ] Certified Records
[ ] Drug/Alcohol treatment records Clinic
[ ] Psychiatric treatment records
[ ] Radiology Films
[ ] Genetic
[ ] Discharge Instructions
[ ] Medication Reconciliation
[ ] OTHER: _____

*A fee for copying medical records will be invoiced to the patient or legally authorized representative in accordance with N.J.A.C. § 8:43G- 15.3(d)(1)(2)(i)-(ii), HIPAA Privacy Standard § 164.524 (c) (4).When payment is received the records will be released. ** For continuing care purposes, there will not be a charge for records sent directly to a physician or facility. ** Processing time will vary due to the status of the record.*

RELEASED TO:

Name: _____ Phone: _____
Address: _____ Zip: _____
Special Instructions: _____
To be: [ ] Picked up [ ] Mailed [ ] Other _____

Unless otherwise revoked by me, this Authorization is **valid for 6 months** from the date above. Revocations MUST be made in writing. Revocation may not be made if action has already been taken in reliance on this Authorization. I have the right to refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, insurance payment or eligibility benefits. When my information is used or shared based on this authorization, the recipient may share it with others and my PHI may no longer be protected by the federal HIPAA Privacy Rule. I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize Primary Care Partners to use or disclose my health information in the manner described above.

Patient Signature _____ Patient Printed Name: _____ Witness _____

If individual is a minor or is otherwise unable to sign this Authorization, please complete the information below:

_____ _____ _____
Signature of authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative — Relationship — Date — Signature of Witness