PATIENT REQUEST FOR UNENCRYPTED EMAIL COMMUNICATION

If you would like to communicate with St. Lucie Eye Associates regarding your appointment, medical status and other details through email, please complete this form. Bring a completed copy with you to the office on your appointment day.

Patient Name: *

Date of birth: *

Email *

Phone Number *

☐ Send me offers and appointment updates through email

This form authorizes your provider to communicate with you via unencrypted email.

I understand that communications over the Internet or use of an email system may not be secure and there is no assurance of confidentiality when communicating via unencrypted email.

Please be advised that:

- An email address must be provided.
- A test email is recommended before corresponding via email.

I understand and agree to the following:

- The email address provided is accurate and I accept responsibility for messages sent to or from this email address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form.
- Communication over the internet or using unencrypted email may not be secure and there is no assurance of confidentiality of information communicated via unencrypted email.
- Email communications may be forwarded to other providers and documented in my medical record for my treatment.
- I have the right at any time to revoke this authorization by contacting my provider and informing them that I wish to revoke my authorization.
- I agree to hold St. Lucie Eye Associates / St. Lucie Optical West and individuals associated with St. Lucie Eye / St. Lucie Optical harmless from any and all claims and liabilities arising from or related to this request to communicate via unencrypted email.

Patient Signature*

Date:

_____ _____

Print form and bring to your appointment