UW MEDICINE AGREEMENT FOR EMAIL CORRESPONDENCE

Patient Name	Date of Birth	Medical Record Number
Address		Email Address

Individual Providers and patients may decide to use email to facilitate communication. Some Providers at UW Medicine may communicate via email, but this agreement does not obligate all UW Medicine Providers to communicate via email. Email may be one of many forms of communication with UW Medicine.

Risk of using email

I want to use email to communicate to UW Medicine Providers and staff about my/the patient's personal health care. I understand that UW Medicine Providers and staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that there are known and unknown risks that may affect the privacy of my personal health care information when using email to communicate. I acknowledge that those risks include, but are not limited, to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- Email may be sent to the wrong address by any sender or receiver.
- Email is easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread computer viruses.
- Email delivery is not guaranteed.

Conditions for the use of email

I agree that I must not use email for medical emergencies or to send time sensitive information to my/the patient's Providers. I understand and agree that it is my responsibility to follow up with UW Medicine Providers or staff, if I have not received a response to my email within a reasonable time period.

I agree that the content of my email messages should state my question or concern briefly and clearly and include (1) the subject of the message in the subject line, and (2) clear patient identification including patient name, telephone number and patient identification number in the body of the message. I agree it is my responsibility to inform UW Medicine Registration of any changes to my email address. I agree that, if I want to withdraw my consent to use email communications about my/the patient's healthcare, it is my responsibility to inform my/the patient's Providers or UW staff member only by email or written communication.

Understanding the use of email

I give permission to UW Medicine Providers and staff to send me email messages that include my/the patient's personal health care information and understand that my email messages may be included in my/the patient's medical record. I have read and understand the risks of using email as stated above and agree that email messages may include protected health information about me/the patient, whenever necessary.

PRINT NAME (Patient or Person Authorized to give authorization)	SIGNATURE	DATE
IF SIGNED BY PERSON OTHER THAN PATIENT, PRINT NAME, PROVIDE REASON, RELATIONSHIP TO PATIENT, DESCRIPTION OF THEIR AUTHORITY		

PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

AGREEMENT FOR EMAIL CORRESPONDENCE

U2270

UH2270 REV JUN 07

WHITE – MEDICAL RECORD
CANARY - PATIENT

AUTHORIZATION – GRAY