Mount Vernon Internal Medicine

EMAIL RELEASE FORM

Date: _____

I, _____ want to communicate via e-mail with Mount Vernon Internal Medicine on matters related to my health and /or my medical treatment. I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, or any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail.

I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

Email: _____

Name: _____

(Print Patient's Name or Name of Patient's Representative)

Signature: _____

(Signature of Patient or Patient's Representative)

Witnessed by: _____

(Must be a MVIM employee)

Signature: _____

(Signature of Witness)