
Patient Authorization for E-mail Communication/Signature Page

It is our recommendation that you use the patient portal that is available on the Minnesota Epilepsy Group website to communicate with your provider. The patient portal provides a secure and encrypted messaging system. If you would prefer to receive communications from Minnesota Epilepsy Group, P.A. via unencrypted e-mail, please read the following and indicate your acknowledgment and consent by signing and dating below.

Authorization to use e-mail

I have been informed of and understand the risks and procedures involved with using unencrypted e-mail to communicate with my providers at Minnesota Epilepsy Group, P.A. I agree to the terms and conditions listed below and hereby voluntarily request, consent to and authorize the use of unencrypted e-mail as one form of communication with my provider, and his/her associates, technicians and other health care providers.

You will be given a copy of this signed form to keep for your records.

I hereby authorize Minnesota Epilepsy Group, P.A. to communicate with me via unencrypted e-mail, including communications regarding my medical care and involving my personal health information. I understand and agree that:

- I will use e-mail for non-emergency purposes only;
- I have received a copy of the Minnesota Epilepsy Group E-mail Policy and have been given the opportunity to ask questions about the policy;
- I understand that e-mail communications from Minnesota Epilepsy Group, P.A. are not encrypted and that the security of such e-mails cannot be guaranteed;
- I have been warned of and accept the security risks to my personal health information associated with the unsecure transmission;
- I understand all e-mail communications will be filed in my personal medical record;
- I understand that I have the right to revoke this Authorization at any time by written request; and
- I agree to inform the office in writing if my e-mail address is changed.

My current e-mail address _____

Patient's printed name _____ Date of Birth _____

Patient's signature _____ Date _____

Guardian's printed name _____

Guardian's signature _____ Date _____