

## **CONSENT for COMMUNICATION via E-MAIL/Text Messaging**

(Provider-Patient)

I, \_\_\_\_\_, hereby consent to have my physician, Dr. Beth Comeau, communicate with me or members of her staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mailing and/or text message regarding the following aspects of my medical care and treatment: [prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail or text messaging.

Signature \_\_\_\_\_ Date \_\_\_\_\_