



MRN:  
Patient Name:

(Patient Label)

**EMAIL CONSENT FORM**

**Response Time:** Discuss with your provider the expected time in which to receive a response. If the expected time is exceeded, call your provider at the phone number below.

**Ending E-Mail Relationship:** Either you or your provider may request via e-mail or letter to discontinue using e-mail as a means of communication.

**Disclaimer:** **UCLA Health System, Santa Monica UCLA Medical Center and Orthopedic Hospital and Stewart and Lynda Resnick Neuropsychiatric Hospital are not responsible for e-mail messages that are lost due to technical failure during composition, transmission and/or storage.**

**I have read and understand the information above, and have had any and all questions answered to my satisfaction. I agree to the guidelines for e-mail communication.**

Patient or Representative Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

If signed by someone other than the patient, please specify relationship to the patient: \_\_\_\_\_

Patient E-mail address (please print): \_\_\_\_\_

Provider Name: \_\_\_\_\_ Telephone Number \_\_\_\_\_

Provider E-mail address (please print): \_\_\_\_\_