UCLA Health System

MRN:
Patient Name:

(Patient Label)

E-MAIL CONSENT FORM

- **UCLA Health System**
- **Santa Monica UCLA Medical Center and Orthopaedic Hospital**
- **Stewart and Lynda Resnick Neuropsychiatric Hospital**

You and your Health care provider have agreed to correspond using electronic mail (e-mail). This form provides guidelines for the intended use of this type of communication, and documents your consent.

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL. CALL 911.

E-mail Use: Generally, e-mail correspondence should be between the provider and an adult patient 18 years or older, or parent or legal guardian of a minor.

Privacy and Confidentiality: Unless your provider tells you specifically that the e-mail will be conducted via a secure server, consider e-mail like a postcard that can be viewed by unintended persons. In addition, the content of the email may be monitored by the hospital to ensure appropriate use.

Discuss with your provider who will process your e-mail messages during business hours, vacations or illness. All e-mails regarding your care will be included in your medical record.

Creating a Message: On the "Subject" line, include the general topic of the message, for example, Prescription or Appointment or Advice. In the body of the message, include your name and your identification number (Medical Record Number) or your date of birth.

Content of the Message: E-mail should be used only for non-sensitive and non-urgent issues. Types of information appropriate for e-mail include:

- Questions about prescriptions
- Routine follow-up inquiries
- Appointment scheduling
- Reporting of self-monitoring measurements, such as blood pressure and glucose determinations

According to the California law, your provider may not communicate any lab results unless your e-mail correspondence is conducted through a secure server. Additionally, e-mail must never be used for results of testing related to HIV, sexually transmitted disease, hepatitis, drug abuse or presence of malignancy, or for alcohol abuse or mental health issues.

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.

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

_____ _____ _____

Signature of patient, parent or personal representative | Date | Time

_____

Relationship (if other than patient)

Patient E-mail address (please print): _____

Provider Name: _____ Phone Number: _____

Provider E-mail address (please print): _____

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