Paul L. Kuflik, M.D.

Consent for Email
Dr. Paul Kuflik

CONSENT FOR COMMUNICATION VIA E-MAIL (PROVIDER-PATIENT)

I, _____, herby consent to have my physician Paul Kuflik, communicate with me or members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding the following aspects of my medical care and treatment: [test results, 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 communication 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 also understand that any e-mail communication between my physician and me or members of his office staff, or between my physician and other physicians, nurse practitioners, or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand at in an urgent or emergent situation I should call my provider or go to the Emergency Room and not relay on e-mail.

Signature: _____ Date _____/_____/_____

E-Mail: _____ @ _____

MR-240 (9/03) (Orthopedics)