



Living-at-Home
Medical

居家樂醫療 Living-at-Home Medical, PC
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PERMISSION TO USE ELECTRONIC COMMUNICATION

I, _____, give consent to Living-At-Home Medical, PC (LAHMed)

Print Patient Name

to communicate with me by email and text message.

I understand that:

1. Standard email and text message communication services are not secure. This means that the messages can be potentially intercepted and read by unauthorized individuals.
2. Living-at-Home will attempt to electronically confirm my identity by requesting a return response to all electronic messages. I will acknowledge that I've read each message by responding.
3. Living-at-Home may route my email or text message to other members of the practice staff for information purposes or for expediting a response. My emails and text messages will not be shared with others outside of the practice without my permission.
4. Living-at-Home will respond within 2 business days (Monday - Friday, non-holidays). If I do not receive a response, I can contact the practice by phone. Email and text messages should not be used for emergencies or time sensitive situations. For time sensitive situations, I will contact the practice by phone. In an emergency, I will call 911. Copies of emails and text messages could be incorporated into my medical record. It is recommend that I retain records for my own files.
5. I may revoke my consent to communicate electronically at any time by notifying Living-at-Home in writing at the address above.
6. I agree to release the provider and practice from any and all liability that may occur due to breach of privacy related to non-secure electronic communication.
7. Medical advice or information specific to any patient's condition will not be transmitted electronically prior to obtaining authorization from the patient or his or her representative.

Signature:

I acknowledge that commonly used email and text message services are not secure and fall outside of the requirements set forth by the Health Insurance Portability and Accountability Act (HIPAA) for communicating protected health information. I have read and understood the above description of the risks associated with electronic communication.

Signature Of Patient or Legal Representative

(If signed by other than patient, state relationship and authority to do so.)

Date