Wilson Eye Associates, Optometrists, PA

Patient Consent/Authorization Request to Receive Personal Email

Email risks include but are not limited to the following:

- **Email can be immediately broadcasted worldwide and received by many intended and unintended recipients;**
- **Recipients can forward email messages to other recipients without the original sender's permission or knowledge:**
- **Users can easily send an e-mail to the incorrect address;**
- **Email is easier to falsify than handwritten or signed documents;**
- **Backup copies of email may exist even after the sender or the recipient has deleted his or her copy;**
- **Without the benefit of face-to-face interaction, emails can be misinterpreted in tone and meaning;**

Patient Name: _____

Please Print

Patient DOB: _____

Last 4 digits of SS#: _____

I am requesting that Wilson Eye Associates, email the following information to me at the following email address.

Email: _____

Please print email neatly and legible

Please list below the requested documents you would like emailed to you.

_____

_____

Please read the following informed consent before signing.

- If you consent to the use of email, you are responsible for informing Wilson Eye Associates, staff of any type of information that you do not want sent to you by email other than the information listed and checked above.
- You are responsible for protecting your password and access to your email account and any email you send or receive from Wilson Eye Associates to ensure your confidentiality. Wilson Eye Associates, doctors and staff cannot be held liable if there is a breach of confidentiality caused by a breach in your account security.
- Any email that you send that discussed your diagnosis or treatment constitutes informed consent to the information being transmitted. If you wish to discontinue emailing information, you must submit a written consent either by U.S Postal service or email informing Wilson Eye Associates that you are withdrawing consent to email information.

_____ **Yes, I have read all information above and consent to encrypted/confidential email of the information I have checked and/or requested.**

Signature of Patient/Parent/Guardian/POA: _____

Print Name and Relationship of the above if not the patient: _____

Date: _____

If parent/Guardian/POA, Cell Phone: _____ Home phone: _____