4070 Lake Dr SE, Ste 101
Grand Rapids, MI 49546
(P) 616-455-4114 (F) 616-455-4454

Patient Name:_________________________ DOB:________

Consent to the Use of Email Communications

Please Note: Communications via un-encrypted email over the internet are not secure and there is a possibility that emails containing personal and/or protected health information, may be intercepted by other parties. You have a right to alternative means, such as US mail or by telephone. 45 C.F.R. § 164.522(b).

Please indicate your preference by placing your initials on the applicable line and signing below.

___ **I CONSENT TO THE USE OF UNENCRYPTED EMAILS**

I understand the risk of using email for sending and receiving protected health information and other personal information. I understand that WMFH cannot diagnose conditions or treat me via email. I understand that I can withdraw or change this consent by notifying WMFH in writing.

Preferred Email Address: ____

_____ **I DO NOT CONSENT TO THE USE OF UN-ENCRYPTED EMAILS, *EXCEPT FOR THE LIMITED PURPOSE OF RE*CEIVING *APPOINTMENT REMINDERS*.**

____ ____________________
Patient (or Parent/Legal Guardian) Signature **Date**