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Patient Request for E-mail Communications

Please read this information carefully.

E-mail communications are two-way communications. However, responses and replies to e-mails sent to or received by either you or me may be hours apart. This means that there could be a delay in receiving treatment for an acute condition.

If you have an urgent or an emergency situation, you should not rely on e-mail to request assistance or to describe the urgent or emergency situation. E-mail messages may be inadvertently missed. Instead, you should act as though e-mail is not available to you and seek assistance by means consistent with your needs.

Unencrypted e-mail messages on your home or work computer, your laptop, and/or your Smartphone have inherent privacy risks and do not provide much privacy. Thus, you should not communicate any important health information via this medium.

Additionally, e-mail is sent at the touch of a button. Once sent, an e-mail message cannot be recalled or cancelled. Neither you nor the person reading your e-mail can see the facial expressions or gestures or hear the voice of the sender. E-mail can be misinterpreted.

At my discretion, your e-mail messages and any and all responses to them may become part of your medical record.

Be also advised that I will not communicate health information that is specially protected under state and federal law via e-mail even if I agree to communicate with you via e-mail.

Despite the above-mentioned risks and limitations in e-mail communications you may request that we communicate via e-mail. To do so, please complete and sign this form.

PATIENT NAME/ NAME OF PATIENT'S LEGAL REPRESENTATIVE:

PATIENT DATE OF BIRTH:

E-MAIL ADDRESS FOR COMMUNICATIONS:

Please check the following boxes:

I acknowledge that I have read and understood this form, and that I have had the opportunity to ask questions about its content.

I understand and acknowledge that communications over the Internet and/or using e-mail are not encrypted and are inherently insecure; that there is no assurance of confidentiality of information when communicated this way.

I agree to hold Carolina Aponte Urdaneta, MD, LLC and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____

DATE: _____