**CONSENT FOR TELEPHONE AND E-MAIL COMMUNICATION**

**MILLER BIOCONNECT / PETER MILLER M.D.**

**I HEREBY CONSENT THAT MY MEDICAL INFORMATION MAY BE COMMUNICATED TO ME OR THE INDIVIDUAL I SPECIFY BELOW BY THE FOLLOWING MEANS:**

**Authorized person’s name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Check mark (√ ) the applicable choices (and fill-in the blank):***

 **E-MAIL [Insert e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]**

 **TELEPHONE [Insert phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]**

 **MOBILE PHONE [Insert phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]**

**I HEREBY CONSENT THAT MY MEDICAL INFORMATION MAY BE COMMUNICATED TO MY OTHER PHYSICIANS AND HEALTHCARE PROVIDERS BY THE FOLLOWING MEANS:**

***Check mark (√ ) the applicable choices:***

 **E-MAIL**

 **TELEPHONE**

 **FAX**

We are advising you in this notice that, if you request that information be provided via email or facsimile, that email and facsimile is each an unsecure medium for transmitting information and that there is some risk if medical information is emailed/faxed. Information transmitted via email/fax is more likely to be intercepted by unauthorized third parties than more secure transmission channels**. If we agree to email/fax information, you are accepting the risks we have notified you of, and you agree that we are not responsible for unauthorized access of such medical information while it is in transmission or upon delivery based on your request.**

**Note:** This consent merely relates to the MANNER in which your information will be communicated. We are otherwise permitted by law to share your information with a third party provider for purposes of treatment and coordination of care, without your consent.

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Signature of patient or patient’s representative Date

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Printed name of patient’s representative Relationship to the patient and authority to sign