THE UNIVERSITY OF IOWA
COLLEGE OF DENTISTRY & DENTAL CLINICS

Patient Name: _____

Patient ID: _____

CONSENT TO COMMUNICATE PHI BY EMAIL

I expressly permit the College of Dentistry and Dental Clinics (COD) to communicate my Protected Health Information (PHI) via email to the e-mail address indicated on my patient registration form, patient record or this form. This permit also applies to any email that the COD may send to my referring dental/medical provider, if appropriate.

E-MAIL RISKS AND YOUR RESPONSIBILITY

If you agree to permit the COD to use e-mail to communicate with you, you should be aware of the following risks and/or your responsibilities:

- As the Internet is not secure or private, unauthorized people may be able to intercept, read and possibly modify email you send or are sent by COD.
- You must protect your e-mail account, password and computer against access by unauthorized people.
- Since e-mails can be copied, printed and forwarded by people to whom you send e-mails, you should be careful regarding whom you send e-mails.

CONDITIONS FOR THE USE OF E-MAIL

By consenting to the use of e-mail with the COD, you agree that:

- The COD may forward e-mails as appropriate for diagnosis, treatment, reimbursement, and other related reasons. COD employees, dental staff and agents, other than the recipient, may have access to e-mails that you send. Such access will only be to persons who have a right to access your e-mail to provide services to you.
- The COD will not forward e-mails to independent third parties without your prior written consent, except as authorized or required by law.
- You should not use e-mail to communicate with the COD if there is an emergency or where you require an answer in a short period of time.
- If your e-mail requires or asks for a response, and you have not received a response within a reasonable time period, it is your responsibility to follow up directly with the COD.
- You should carefully consider the use of e-mail for the communication of sensitive medical information, such as, but not limited to, information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- The COD reserves the right to save your e-mail and include your e-mail or information contained within your e-mail in your dental record.

INSTRUCTIONS

- You should immediately inform the COD if you change your e-mail address.
- You should put the patient name and date of birth (used to verify your identity) in the body of the e-mail.
- If you wish to withdraw your consent to communicate by e-mail, you must send an e-mail to the COD stating such.

ACKNOWLEDGMENT AND AGREEMENT

COD will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, the COD cannot guarantee that e-mail will be confidential. Additionally, the COD will not be liable in the event that you or anyone else inappropriately uses or accesses your e-mail. The COD will not be liable for improper disclosure of your health information that is not caused by the COD's intentional misconduct.

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of e-mail between the COD and me, and consent to the conditions outlined herein, as well as any other instructions that the COD may impose to communicate with me by e-mail. Any questions I may have had were answered. I understand that this consent is valid until such time as I revoke the consent as outlined above, except to the extent that a person who is to make a communication has already acted in reliance upon this authorization.

Signed: _____ Date: _____

Printed: _____ Relationship to patient: _____

EMail address: _____ Patient Date of birth: _____