Please Note: If you have received this form by mail, please bring it with you to your next appointment. Thank you.

FAX & EMAIL PRIVACY WAIVER

Cannon Physician Practices

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur I absolve this practice of all liability.

I give my consent to fax my records for the purposes of treatment, payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

If I choose to email my healthcare provider(s), I understand that email is considered a convenience and is not appropriate for emergencies or time-sensitive issues. I also understand that highly sensitive or personal information should not be communicated via email.

I understand that although safeguards will be made to protect the confidentiality of any information contained within email, no one can guarantee the absolute privacy of email messages and that depending on their job function, staff may have the right to access any email sent or received by my healthcare provider(s).

I give my consent to include any emails pertinent to the treatment, payment or healthcare operations in my medical record. Finally, I understand that I may withdraw this consent at any time in writing.

_____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____
PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_____
RELATIONSHIP TO THE PATIENT (if applicable)

_____
DATE

FOR OFFICE USE: Office copy, place in patient's record