Consent for use of Physician-Patient E-Mail

Family Beginnings, PC

8435 Clearvista Pl.
Suite 104
Indianapolis, IN 46256
317-595-3665

I, _____, hereby give my consent to have electronic e-mail communication with Family Beginnings, PC. I understand that I must be an established patient of the Practice and that I have completed all forms required by the Practice to be a patient of the Practice. I will not use email for emergency communication or to schedule appointments. For a life-threatening emergency I will call 911 or go to the nearest ER. I understand that the primary purpose of this communication is patient education. I understand and accept that electronic communication may not be completely private even with certain safeguards in place and I hold Family Beginnings, PC harmless for any situation arising out my electronic communication with the Practice or violations of HIPAA. I understand that data may be lost, failed to download or accidentally deleted. I understand that I always have the option to meet in person with the Physician to be sure that all of my questions and concerns are answered. I understand that there is no set time that emails may be read and that they may not be answered in a timely fashion. For immediate information I will call the office and speak to the staff or make an appointment.

Patient_____
Witness_____

Date_____