HEADWATERS
Health Care Centre

Patient Consent for E-mail Communication Agreement

Section A: Terms and Conditions / Consent to Email Communication for Patient Care Purposes

***Instructions:* Headwaters Health Care Centre (Headwaters) communicates with patients and families primarily through the phone and in person. Before Headwaters Health Care Centre can communicate to you via email, we must explain the terms, conditions and risks involved, and ask for your written consent. Please read the information below carefully, sign and return to Headwaters Health Care Centre by email or fax**.

Name of Patient: ______________________________

Name of Substitute Decision Maker (if applicable): ______________________________

Relationship of Substitute Decision Maker to Patient (if applicable): ______________________________

I give consent to the health care providers and staff involved in my/the patient's care from:

______________________________ at Headwaters Health Care Centre to
NAME OF DEPARTMENT

communicate with me via email using the following email address(es): ______________________________ for the following purposes:

☐ Scheduled appointment reminders and related pre-appointment preparations

☐ Other - Specify: ______________________________

While email communication has many advantages, it also comes with risks that we want to be sure you are aware of. Please review the following information carefully and sign the agreement to indicate you are accepting the following risks associated with email communication:

- Email communication is not considered to be a secure or confidential form of communication. Unencrypted email messages that are sent across the internet could potentially be read by unintended parties. Headwaters cannot guarantee the security of information outside of Headwaters' network.
- Email messages may be delayed for technical reasons or may unintentionally be filtered and sent to junk or trash folder.
- Even after messages are deleted, copies can still exist on back-up computer systems.
- Although Headwaters' devices have anti-virus software, viruses and malware may be unintentionally transmitted by email.
- Headwaters will not be liable for any harmful consequences that may arise from communication over the internet or use of online services made available by Headwaters.

I understand that:

- Headwaters handles patient personal health information. The organization and all staff are dedicated to the protection of this information. The organization is required to uphold privacy legislation and takes responsible steps to have safeguards in place.
- Headwaters' health team will not use email to communicate information of a sensitive nature or to convey emergency advice.
- Decisions regarding my/the patient's care may be made on the basis of health information provided by me in email messages.
- A printout of any email communications related to my/the patient's care will be placed on the health record.
- Either party may stop communication via email at any time for any reason. This form will be valid until consent is withdrawn.

Please provide your consent below. You can change your consent at any time and ask questions to Headwaters Health Care Centre. You are not required to consent if you do not wish.

Date: ____________________ ______________________________
YYYY/MM/DD SIGNATURE OF PATIENT OR SUBSTITUTE DECISION MAKER

Date: ____________________ ______________________________
YYYY/MM/DD NAME (PLEASE PRINT) AND SIGNATURE OF HHCC STAFF/AFFILIATE OBTAINING CONSENT

If it is not possible to sign in ink above, please check the box below to attest this statement:

☐ I have spoken over the phone with a representative from Headwaters Health Care Centre, completed this form to reflect my consent and attest that I am the person that I say I am.

Section B: Telephone Consent (To be completed by Health Care Provider Only)

I, ______________________________ have spoken with ______________________________
PRINTED NAME OF HEALTHCARE PROVIDER NAME OF PATIENT OR SUBSTITUTE DECISION MAKER

by telephone as he/she is not able to attend at the hospital to sign the written consent form. Communication of the consent form by facsimile or other electronic transmission is not reasonably available. I have obtained informed consent over the telephone with,

______________________________ on __________ at ________ by ______________________________
NAME OF PATIENT OR SUBSTITUTE DECISION MAKER YYYY/MM/DD HH:DD SIGNATURE OF HEALTH CARE PROVIDER

COMPLETED FORM TO BE PLACED ON PATIENT'S HOSPITAL RECORD.