Patient Consent to Email Protect Health Information

Patient's Name (Print): _____

I understand that any email communications received by or sent from Northeast Wisconsin Foot and Ankle is currently unprotected (meaning, if someone intercepts the email the information will be readable). Acknowledging this potential risk, I am authorizing Northeast Wisconsin Foot and Ankle to contact me via email which may include transmitting my Protected Health Information (PHI). Should my PHI in any way become compromised due to an email transmission, I will hold Northeast Wisconsin Foot and Ankle Associates, SC, it's owners, physicians, and staff harmless of any liability resulting from the loss or interception of my PHI from an unauthorized party . I also understand that this authorization will remain in effect from the date on this form and until I communicate in writing to the contrary.

I therefore authorize Northeast Wisconsin Foot and Ankle Associates to email my PHI information to the following address: _____.

_____ _____

Patient's Signature Today's Date