MAYO CLINIC

Electronic Mail Authorization

Number (above) and Name

I, _____ (Patient Name), _____ (Mayo Clinic Number), whose e-mail address is _____ request and authorize you, _____ (Healthcare Provider), Mayo Clinic and its staff, to communicate with me and other authorized healthcare providers involved in my care about any aspect of my health and medical care by means of electronic mail. By giving this authorization I demonstrate an understanding of the following issues related to the use of electronic mail:

- I understand electronic mail is not appropriate for communication about all health issues, particularly those of an urgent nature and Mayo can make no guarantee of response within a certain time frame.
- I understand that electronic mail is not encrypted and therefore not as confidential as mail or telephone communication.
- I understand that it is possible for a third party, including an employer, to intercept or read electronic mail without knowledge of either the sender or recipient of the mail. Because of the ease and informality with which electronic mail can be used and because electronic mail may be easily rebroadcast to multiple addresses, the potential loss of confidentiality associated with its use may be of greater consequence than that suffered with written or telephone communication.
- Since Mayo does not operate or control any service on the internet, I understand Mayo cannot and does not guarantee that use of this means of communication will be free from technological difficulties including, but not limited too, loss of messages.
- I understand that information communicated by means of electronic mail will be incorporated and retained within the Mayo medical record. As a result, that information, including, but not limited to my electronic mail address, may be disseminated as part of an authorized release of a copy of the medical record.

My signature below denotes that I accept the risk of loss of privacy of confidential medical information associated with communication by electronic mail and nonetheless, agree to its use. I also agree that Mayo shall not be liable for any type of damage or liability arising from or associated with loss of confidentiality due to communication by electronic mail.

This authorization for communication by means of electronic mail is valid until I notify you in writing I no longer authorize the use of electronic mail to communicate information concerning my medical care. Mayo also retains the right to terminate electronic mail as a means of communication at any time if such becomes, in the healthcare provider's judgement, burdensome or inappropriate.

Signature of patient, guardian, authorized representative

Date

Please Note: Questions concerning the appropriateness of communication by means of electronic mail should be resolved prior to signing above.