NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

This Notice of Privacy Practices is being provided to you on behalf of Seattle Reproductive Medicine with respect to reproductive medical services provided at Seattle Reproductive Medicine's facilities (collectively referred to herein as "We" or "Our"). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." Protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

Your Rights

Although your health record is the physical property of Seattle Reproductive Medicine, you have the right to:

- request a restriction on certain uses and disclosures of your information as provided by applicable law
- obtain a paper copy of this Notice of Privacy Practices upon request
- inspect and copy your health record as provided for by applicable law
- request an electronic copy of your electronic health record
- request to amend your health record as provided by applicable law
- obtain an accounting of disclosures of your health information as provided by applicable law.
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- request a restriction of disclosure of your healthy information to your health insurer for services for which you pay "out of pocket" in full
- transmit copies of your health information to third parties when requested by you, in writing

Our Responsibilities:

We are required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- where required by law, notify you if there has been a breach of your unsecured health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revised Notice of Privacy Practices on our website at www.seattlefertility.com as well as at our offices and provide you with a hard copy upon request.

We will not use or disclose your health information without your authorization, except as described in this notice unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse, danger to self or others).

We will not sell your health information (unless permitted by law) or use or disclose such information for paid marketing (for which we receive payment from a third party) without your authorization. If we obtain your authorization, you may revoke it at any time, and this revocation will take effect except where we have already relied upon your authorization.

Permitted Uses and Disclosures

*We will use and disclose your health information for **treatment**. For example:* information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you are discharged from this practice.

*We will use and disclose your health information for **payment**. For example:* A bill may be sent to you or a third-party payor, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you receive. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used during treatment.

*We will use and disclose your health information for our **health care operations**. For example:* Members of the clinical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and the reproductive medicine service we provide.

Other Uses or Disclosures of Protected Health Information

Business Associates: There are some services provided at Seattle Reproductive Medicine through contacts with business associates. For example: certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payor for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Spouse/Family: Health professionals, using their best judgment, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: Where permitted by law, we may contact you to tell you about or recommend possible treatment alternatives or other medical technology and services that may be of interest to you. We may also seek your authorization to contact you with other marketing communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Note: HIV-related information, genetic information, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

For More Information or to Report a Problem/Complaint:

If you believe your privacy rights have been violated, you may file a complaint with us by contacting **Breanne Ross, Clinical Programs & Compliance Specialist: (206) 301-5000.**

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint about our privacy practices.

If you have any questions or would like further information about this notice, please contact Brad Senstra, Executive Director at the above phone number. This information also available on our website at: www.seattlefertility.com.

FINANCIAL POLICY

This statement describes your financial responsibilities as a patient at Seattle Reproductive Medicine (SRM). Please direct any questions you may have to our Finance Department.

Financial Counselors: As a patient of SRM, our team of financial counselors are available to assist with the financial elements of your fertility journey. These services consist of, but are not limited to the following:

- Providing clarity and information related to your financial obligations
- Estimating the cost of your proposed treatment
- Outlining payment options available to you
- Assistance with understanding insurance benefits
- Connecting you with benefit plan personnel

Insurance: At each visit, please be prepared to present proof of current insurance, regardless of coverage. If you fail to provide us with your correct insurance information in a timely manner, you will be responsible for payment of services rendered. If your insurance changes, please notify us before your next visit to help you receive your maximum benefits. Failure to notify us of insurance changes may result in denial of claims and patient responsibility for payment of the denied claim. You are responsible to verify your insurance benefits and to ensure appropriate insurance referrals are obtained prior to services being rendered. SRM Financial Counselors are available to assist in this matter, however, failure to do so may result in your financial responsibility for services. If a referral is required by your insurance carrier and not obtained, the appointment will be treated as self-pay.

If we are billing your insurance, your deposit for estimated patient responsibility is due for known deductibles, coinsurance, co-payment, and non-covered services or contract excluded services prior to the start of your ART cycle (IVF, FET).

Co-payments: Co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Non-covered services: Our providers follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some services you receive may be determined by your insurance plan to be partially covered or not covered. You will be financially responsible for the cost of services that are not paid.

Non-billable Services: Phone consultations, acupuncture and psychological counseling are currently not billable to insurance. You will be responsible for filing claims if these services are covered by your plan.

Telemedicine: Unless otherwise specified, I consent to telehealth visits (video or telephone). These appointments may be billable to your insurance if covered by your benefit plan. If the charge is denied by your insurance the balance will become patient responsibility.

Claims submission: Your insurance benefit is a contract between you and your insurance company. We will submit your claims only if we have determined that you have a benefit for the services rendered. We do not courtesy-bill insurance if we have been advised there's no coverage for the services. Your insurance company may need you to supply certain

information directly to process a claim. It is your responsibility to comply with their request(s). **Please be aware that any amounts not covered by your insurance company will be your responsibility.**

Missed and no-show new patient appointments: If you cancel your initial appointment with less than 48-hours' notice twice or no-show twice, you will be notified that a $350 non-refundable deposit will be required to schedule your third new patient visit. This advance payment will be applied to the charges for your appointment. If you no-show or cancel with less than 48-hours' notice for the third scheduled new patient appointment you will forfeit the $350 deposit.

Refunds: In the event you have overpaid your account, the credit will remain on your account to be applied to future services if treatment is ongoing. If treatment has been discontinued, a refund check will be mailed to you after all pending balances have been paid on all accounts. In the event SRM is unable to contact you or the refund check is not cashed, and more than three (3) years has elapsed after becoming payable, the balance will be reported to the State of Washington as Unclaimed Property in accordance with RCW 63.29.170.

Storage Fees: You are strongly encouraged to enroll in our auto-payment process for any specimen stored at SRM. We will provide you with the auto payment enrollment form once you have any specimen stored. Storage fees are posted to your account by the 10th of each month. Please understand you will be billed per specimen type (embryos, oocytes, or sperm) per month.

Past due balances: Payment is due in full at the time a billing statement is received. If any invoice remains unpaid for more than sixty (60) days, we may cease performing services for you until you make satisfactory arrangements to pay your bill. If the delinquency continues, we will make written and verbal efforts to notify you of any past due balances on your account. After a balance is 120 days past due, SRM may engage an attorney or collection agency to collect any past due balance. Attorney and/or court fees may be charged to you and collected in accordance with Washington State law.
Accounts which are 120 days or more past-due and sent to collections will be assessed a fee based on the table below. This fee will be added to the outstanding balance due.

Outstanding Balance	Fee
$0.01-$500.00	$50
$500.01-$1,000.00	$75
$1,000.01-$1,500.00	$100
$1,500.01-$2,000.00	$125
$2,000.01-$2,500.00	$150
$2,500.01-$3,000.00	$200
$3,000.01-$3,500.00	$225
$3,500.01 and greater	$250

Accepted Payments: SRM accepts Visa, MasterCard, American Express, Discover, cash, wire transfer, money order, cashier's check, or financing from our partner lender. Payments may be made over the phone, in any of our offices, or online by visiting our website (www.seattlefertility.com). Please inquire with any of SRM's Financial Counselors for information related to third-party financing.

Returned checks: A fee of $25.00 will be assessed for each returned check.

PATIENT RIGHTS AND RESPONSIBILITIES

Your Rights – As a patient, you have the right to:

- Be treated with respect, consideration, and dignity.
- Treatment without regard to sex, cultural, economic, educational, or religious background or the source of payment for your care.
- Be provided appropriate privacy at check-in and in treatment areas. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual.
- Privacy regarding all communications and records pertaining to your care. Your written permission shall be obtained before your medical records are made available to anyone not concerned with your care.
- Interpretation services.
- Knowledge of the name of the provider who has primary responsibility for coordinating your care and the names and professional relationships of other providers from whom you may receive care.
- Be provided with information about your diagnosis, evaluation, treatment, and prognosis to the degree that it is known. This information shall include a description of the treatment or procedure, alternate course of treatment or non-treatment, and the medically significant risks involved. This information will be provided in terms you can understand. You will be given the opportunity to participate in decisions involving your health care and to give informed consent or to refuse treatment, except when such participation is contradictory for medical reasons. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by you or to a legally authorized person.
- Reasonable responses to any reasonable request you make for services.
- Be informed by your provider or designee of your continuing health care requirements.
- Be informed of unanticipated outcomes.
- Reasonable continuity of care and to know in advance the time and location of appointments as well as the provider administering the care.
- Be advised if the provider proposes to engage in or perform human experimentation affecting your care or treatment. The patient has the right to refuse to participate in such research projects.
- Examine and receive an explanation of your bill regardless of source of payment.
- Have all patient rights explained to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
- Family input in care decisions, in compliance with existing legal directives of the patient or existing court-issued legal orders.
- Complain about your care and treatment without fear of retribution or denial of care.
- Resolving problems with care decisions and/or complaints in a timely manner.
- You have the right to change providers if other qualified providers are available.
- Protection from abuse or neglect.
- Access to protective services.
- Express any grievances or suggestions verbally or in writing to Seattle Reproductive Medicine Management and/or the Accreditation Association for Ambulatory Healthcare at 847-853-6060 or Washington Department of Health Complaint Hotline at 800-633-6828.

Please visit http://www.seattlefertility.com to learn about our practice, philosophy, and team members.

Your Responsibilities – As a patient, you have the responsibility to:

- Communicate with your provider. Communication is essential to a successful provider-patient relationship.
- Provide complete and accurate information to the best of your ability about your health. This shall include past illnesses, hospitalizations, family history of illness, any medications taken including over-the-counter products and dietary supplements, and any allergies or sensitivities.
- Follow the agreed-upon treatment plan prescribed by your provider and participate in your care. Compliance with provider instructions is often essential to public and individual safety. As a patient, you also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when you would like to reconsider the treatment plan.
- Request information or clarification about your health status or treatment when you do not fully understand what has been described.
- Accept personal financial responsibility for any charges not covered by insurance.
- Behave respectfully towards all health care professionals and staff, as well as other patients and visitors.
- Provide a responsible adult to transport you home and to remain with you as directed by your provider after receiving any anesthetic and/or sedative medications.

PRECONCEPTION HEALTH

Genetic Disorders: The American College of Obstetricians and Gynecologists (ACOG) and the American College of Medical Genetics (ACMG) recommends testing for certain genetic diseases based on ethnicity, family history, or other known risk factors and testing for certain contagious diseases that can be harmful to a fetus, prior to pregnancy.

Genes typically come in pairs, with one copy from each reproductive partner. Genetic screening can identify individuals who carry mutations on one or more of their genes. The "carriers" are typically healthy, have no symptoms of a genetic disease, and often do not have any associated family history. When reproductive partners carry a mutation within the same recessive gene, there is a 1 in 4 or 25% chance that each offspring will develop the correlating genetic disorder. However, if one partner's screening is negative, the risk of having an affected child is greatly reduced. SRM recommends and encourages genetic screening for one or both reproductive partners prior to attempting pregnancy.

Contagious Infectious Disease: Infections such as Chickenpox (Varicella) and German Measles (Rubella) can have serious consequences if acquired during pregnancy. Screening is recommended to confirm your immunity status, even if you have previously had the disease, or previously had a Rubella or Varicella vaccination. Immunity may have worn off, or not been achieved, in which case, the diseases can be prevented with targeted immunizations administered prior to pregnancy.

Influenza (seasonal flu) is a potentially serious disease and is more likely to cause severe illness in pregnant individuals. Vaccinations can be given anytime, including in pregnancy. It is recommended that people who are pregnant, or attempting pregnancy, get vaccinated annually against the flu.

Zika Virus: SRM follows the Center for Disease Control (CDC) and the American Society for Reproductive Medicine (ASRM) recommendations for Zika precautions. Current recommendations include avoiding travel to areas with active Zika virus transmission when trying to conceive and during pregnancy. Individuals who have traveled, or plan to travel, to an area with a Zika virus travel notice should wait the recommended timeframe before attempting pregnancy. Please visit the CDC website to review areas of active Zika virus transmission, and to review the identified methods for preventing exposure if you must travel to an area of risk. https://www.cdc.gov/zika/pregnancy/women-and-their-partners.html

TREATMENT DURING COVID-19

COVID-19 is a disease caused by the SARS CoV-2 virus, which is spread to people primarily through droplets and very small particles that contain the virus. Pregnant individuals are at higher risk of severe illness due to COVID-19 including intensive care unit (ICU) admission, receipt of mechanical ventilation and death compared with nonpregnant individuals. In addition, there is an increased risk of preterm birth with associated higher risk of complications of prematurity for the baby. In the first trimester, febrile illness from any cause may be associated with increased risk of miscarriage or anomalies. Irrespective of pregnancy status, severe illness occurred more often among people aged 35-44 years than among those under 35.

Professional organizations, including the American College of Obstetricians and Gynecology (ACOG), the American Society of Reproductive Medicine (ASRM), and the Centers for Disease Control and Prevention (CDC), recommend COVID-19 vaccination for all eligible individuals. There is agreement among these institutions that the safety and effectiveness of COVID-19 vaccination outweigh any know or potential risks associated with receiving the vaccine. The v-safe registry of vaccinated individuals shows no increase risks of adverse pregnancy or neonatal outcomes compared with expected outcomes in the general pregnancy population. The available evidence indicates that the vaccine does not lead to loss of fertility, miscarriage, or congenital anomalies.

SRM takes the health and safety of our patients and staff seriously. We strongly urge all pregnant individuals–along with those who are undergoing fertility treatment or are lactating–to be vaccinated against COVID-19. This recommendation includes the booster shot when criteria are met based on CDC guidelines. Vaccination administration should not delay any pregnancy attempts; However, we do advise against receiving the COVID-19 vaccine within three (3) days of any surgery or outpatient procedure, including oocyte (egg) retrieval, embryo transfer, and intrauterine insemination to avoid possible interference with anesthesia monitoring and/or cancellation due to vaccine symptoms.

Documentation of Vaccination: A copy of your vaccination card will be required prior to proceeding with assisted reproductive services at SRM. If you have been vaccinated, please upload your COVID-19 vaccination card to the SRM portal to be added to your medical record. A waiver will be required for any individuals declining vaccination. Please note, SRM requires vaccination for all gamete donors and gestational surrogates.

Infection Prevention: We ask that all patients of SRM take measures to ensure their health and prevent spread of infection including frequent hand washing, physical distancing, and wearing a mask. Every effort will be made to reduce risk of exposure during evaluation and treatment at SRM; however, some residual risk may still be present. There is the potential for treatment cancellation due to exposure, infection, availability of PPE, or changes in regulations. There also may be limitations of COVID-19 testing. Please be aware that masks are required in healthcare settings, regardless of vaccination status.

If you have been diagnosed with COVID-19, directly exposed to, or have symptoms associated with COVID-19 (even without a positive test), please do not come to the clinic. We encourage you to contact your primary care provider for guidance and alert your SRM care team.

TELEMENTAL HEALTH SERVICES

Telemental health is the use of telecommunications or videoconferencing technology to provide mental health services in lieu of, or in addition to, traditional face-to-face methods. SRM offers psychological counseling with a licensed Mental Health Professional via an online HIPAA compliant, secure video service. Please read this information carefully to acknowledge and provide consent to the use of teletherapy.

- There are risks, benefits, and consequences associated with tele mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- It may be determined that telemental health services are not appropriate for you in which case, referrals to another professional in your area may be discussed.
- There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. If your records are requested by a valid subpoena or court order, we must respond.
- You have the right to withdraw consent at any time without affecting your right to future care, services, or program benefits to which you would otherwise be entitled.

Psychotherapy notes and psychometric testing reports will remain confidential and will only be viewed by qualified professionals at SRM and will not be released to as part of the medical records.

Limits of Confidentiality: The privacy laws that protect the confidentiality of protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies. Exceptions to confidentiality include:

- *Duty to Warn:* It is required by law to disclose pertinent information if a patient has an intent or plan to harm another person. This may include informing the intended victim and notifying legal authorities.
- *Abuse:* It is mandated by law to report stated or suspected abuse or harmful neglect of children or vulnerable adults to the appropriate state agency and/or legal authorities.
- *Suicide/Self-Harm:* If a patient is having suicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, a higher level of care may be required (i.e., hospitalization; contact emergency contact and/or appropriate authorities).

VIDEO AND AUDIO RECORDINGS

SRM has the following policy regarding audio and/or video recordings during consultations and procedures:

- No hidden recordings of any nature may be used.
- Audio or video recordings may be undertaken only with the consent of the provider.
- Audio recordings, if consented, may only be used during a consultation.
- Video recordings, if consented, may only take place after a procedure is completed to review or recap the procedure. This recording will be strictly at the discretion of the provider.
- Any recording made must be with the understanding that this is for personal use and not to be published.
- Permission to record employees, facilities, machinery, results (sonograms, etc.) or fellow patients is prohibited.

ACKNOWLEDGEMENT AND CONSENT

I acknowledge that I have read and understood Seattle Reproductive Medicine's *Notice of Privacy Practices*. This signature is required for Seattle Reproductive Medicine to bill your insurance.

I acknowledge that I have read and understood Seattle Reproductive Medicine's *Financial Policy*.

I acknowledge that I have read and understood my *Patient Rights and Responsibilities.*

I acknowledge that I have read and understood Seattle Reproductive Medicine's *Preconception Health.*

I acknowledge that I have read and understood Seattle Reproductive Medicine's *Treatment During COVID-19.*

I acknowledge that I have read and understood Seattle Reproductive Medicine's *Telemental Health Services.*

I acknowledge that I have read and understood Seattle Reproductive Medicine's *Video & Audio Recording Policy*.

I acknowledge SRM's 24-hour Emergency Paging 206-301-5000 for after hours and emergency care.

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth

AUTHORIZATION FORM TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO SPOUSE/SIGNIFICANT OTHER

This authorization grants permission to my Spouse / Significant Other / Party Named Below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications; be made aware of my diagnosis, prognosis, and fertility treatment plans; and have access to my financial health information. Please complete the form in its entirety to be valid.

Patient Name (please print): _____

Date of Birth: _____

Spouse / Significant Other / Other: _____

Relationship to Patient: _____

Phone: _____

I hereby authorize Seattle Reproductive Medicine to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to my spouse / significant other, or the party named above, the released information may no longer be protected by federal privacy regulations.

I understand that this authorization will be effective for the lifetime of the patient unless revoked. I understand that I may revoke this authorization at any time by notifying Seattle Reproductive Medicine in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Seattle Reproductive Medicine prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization.

_____ _____

Patient Signature Date

Disposition: Completed Authorization to be scanned into the patient medical record.

* * YOU MAY REFUSE TO SIGN THIS AUTHORIZATION * *

ELECTRONIC COMMUNICATION CONSENT

Email communication provides for a fast and easy way to communicate with your healthcare team for those issues that are nonemergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient healthcare provider/team relationship; rather it can support and strengthen an already established relationship. The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

General Considerations

- Email communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard email communication services, such as AOL, Yahoo and Hotmail are not secure. This means that the email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals.
- Your email address will not be used for external marketing purposes without your permission. You may receive a group emailing from the practice; however, the recipients' email addresses will be hidden.

Healthcare Team Responsibilities

- Staff will attempt to electronically confirm your email address by requesting a return response to all email messages.
- Your provider may route your email messages to other members of the staff for information purposes or for expediting a response.
- Designated staff may receive and read your email.
- Every attempt will be made to respond to your email message within 2 business days (Monday – Friday, non-holidays). *If you do not receive a response from the practice within 2 business days, please contact the practice by phone.*
- Copies of emails sent and received from and to you could be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

Patient Responsibilities

- Email messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should immediately call 911. For emergent or time sensitive situations, you should contact the practice by phone.
- Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via email.
- Please include your full name and the topic, i.e., medication question, in the subject line. This will serve to identify you as the sender of the email.
- Please acknowledge that you received and read the message by return email to the sender.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with my healthcare team. I acknowledge that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information. I have been given the opportunity to discuss electronic communication with a representative of SRM and have had all my questions answered. In consideration for my desire to use electronic communication as an adjunct to in-person office visits with my healthcare team, I hereby consent to electronic communication via non-secure email services. I understand that I may revoke my consent to communicate electronically at any time by notifying the practice in writing, but if I do, the revocation will not have an effect on actions my healthcare provider or team has already taken in reliance on my consent. I agree and release my provider and practice from any, and all liability that may occur due to electronic communication over a non-secure network. I further agree to be held accountable and to comply with the patient responsibilities as outlined in this consent.

Patient Authorized Email Address (please print legibly)

Patient Signature _____Print Name _____ Date _____