NORTH SHORE MEDICAL CENTER

1100 NW 95th ST
MIAMI, FL 33150

HEALTH INFORMATION MANAGEMENT DEPARTMENT

PHONE: (305) 835 – 6179 FAX: (833) 503 - 4041

CONSENT FOR EMAIL COMMUNICATION OF PATIENT HEALTH INFORMATION

As a health care provider, providing access to your records in a secure manner while balancing ease of access is important to us. You have requested that we transmit a copy of your records, which may contain your Protected Health Information (PHI), via email. We are required by law to notify you that email is not a completely secure means of communication due to the fact that messages can be addressed to the wrong person or messages can be intercepted during transmission by a third party.

If you acknowledge the above risks still would like for us to send your information via email, please print clearly, sign and complete the consent below. You are not required to authorize the use of email, and any decision not sign this form will not impact your health care or treatment at this provider. Please note – due to some email providers, certain size files may not be transmitted. In the event that there is trouble with transmission, we will place your records on a CD and mail them to you.

I acknowledge the above risks and consent to the use of email to distribute my Protected Health Information (PHI).

Printed Name: _____

Medical Record Number: _____

Date: _____

Signature: _____

Email Address to send
PHI/ Medical Records: _____

Home Address: _____