Manhattan Endocrinologist, PLLC

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E-MAIL CONSENT

I, ____ hereby consent to have my physician Dr. Olga Leonardi / Dr. Salas-Whalen, communicate with me or members of his/her staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mailing regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mailing is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and I, or members of the physician's office staff, or between my physician or other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and I, or members of his/her staff, or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call the provider or go to the Emergency Room and not rely on e-mail.

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NAME (Print/Sign)

____

DATE