Houston Rheumatology & Arthritis Specialists

Patient Consent for Use of Email Communication

To better serve our patients, out office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at **info@myhras.com** Please remember however, that this form of communication is not appropriate for use in an emergency. **The turnaround time for routine patient communications is 3 business days.** The service provider may delay message delivery. Should you require urgent or immediate attention, this medium is not appropriate.
When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, date of birth, and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.
Communications relating to diagnosis and treatment will be filed in your medical record. This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to your physician, staff and covering physician would have access to this information.
I understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.
By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

_____   _____
Patient signature   Witness (optional)

_____
Date