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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND OFFICE POLICIES

By signing below, I attest that I have received notice of the Privacy Policies and Office Practices of Sarah Fishman MD, PhD PC on the date indicated. I understand any questions I have regarding these privacy and office policies may be directed to the patient privacy officer indicated in this notice.

CONSENT TO USE OF EMAIL COMMUNICATION

I hereby consent to communication with Dr. Sarah Fishman and any members of her staff via email, text message, SMS, and other electronic communication regarding my medical care including but not limited to test results, treatment options, appointments, imaging studies and medications. I understand that e-mail and other electronic communication is not a confidential means of communication and that e-mails and electronic communication initiated by me intended for Dr. Sarah Fishman and/or her staff or initiated by Dr. Sarah Fishman and/or her staff intended for me may be intercepted or unintentionally transmitted to third parties. Any email or other electronic communication between myself and Dr. Sarah Fishman and/or her staff may be printed and added to my medical record. I acknowledge that any electronic communication via email or text is not a substitute for direct medical care and that in the event of an urgent or emergency situation, I should attempt to contact a medical provider by phone or go to an emergency room and not rely on email or other electronic communication.

_____ ____/____/____

Patient's Name (Print) Date of Birth (mm/dd/yyyy)

_____ ____/____/____

Signature of Patient/Responsible Party (Representative Status) Date (mm/dd/yyyy)

If the above person is the legal representative of the patient, please write the patient name directly above, and indicate your name and legal representative status giving you the authority to sign on behalf of the patient.