Mount Sinai *Dubin Breast Center*
of The Tisch Cancer Institute

Consent for Communication Via E-Mail (Provider to Patient)

Name

Date of Birth

MRN

I, _____ , hereby consent to have my physician, _____ , communicate with me or members of their staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding aspects of my medical care and treatment (test results, prescriptions, appointments, billing, etc.). I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff or between my physician and 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 me or members of their office 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 my provider or go to the Emergency Room and not rely on e-mail.

Email

Signature

Dated