ORTHOCARE
PHYSICAL THERAPY CENTER

PATIENT CONSENT TO EMAIL RECORDS

Patient Name: _____ **Date of Birth:** _____

Email Address: _____

1. Authorization

I, the undersigned patient (or legal guardian), request and authorize Orthocare Physical Therapy Center to communicate with me and/or send my protected health information (PHI), including medical records, test results, and billing information, via email.

2. Risk Acknowledgement

I understand that standard email is **not a secure method of communication**. I acknowledge and accept the following risks:

- Email can be intercepted, altered, forwarded, or stored improperly.
- Email accounts can be hacked, leading to unauthorized access to my health information.
- Messages can be sent to the wrong address, or mistakenly read by others.
- Orthocare Physical Therapy Center cannot guarantee the absolute confidentiality of information sent via email.

3. Patient Responsibility

I agree to inform Orthocare Physical Therapy Center immediately of any change to my email address. I understand that I am responsible for securing my own email account, including using a strong password.

4. Revocation of Consent

I understand that I may revoke this consent at any time, but I must do so in writing to Orthocare Physical Therapy Center. Revocation will not affect actions taken prior to the receipt of my written request.

5. Waiver of Liability

I agree to hold Orthocare Physical Therapy Center harmless for any unauthorized use, disclosure, or access of my protected health information that may occur during, or as a result of, the transmission of such information via unencrypted email.

6. Signature

I have read and fully understand this form and consent to the use of email for my medical information.

_____

Signature of Patient/Guardian Date

_____

Name of Patient/Guardian (if applicable)

13135 Lee Jackson Memorial Hwy, Ste 320, Fairfax, VA 22033
Phone: 703-310-7610; Email: info@orthocareptc.com