Hamilton Health Sciences

CONSENT FOR E-MAIL CORRESPONDENCE

Patient's Last Name First Name

Address - Street City

HIN

Patient's Birth Date (yyyy / mm / dd) Age Gender ☐ M ☐ F

Family Physician

I _____,
Print name of Patient or Substitute Decision Maker (SDM)

Email address _____

have requested that Hamilton Health Sciences (HHS), correspond with me by e-mail for the following reason(s):

_____.

I understand that e-mail is not a secure method of communication and therefore Hamilton Health Sciences (HHS) cannot guarantee the security of messages sent by this method between myself and the hospital.

I understand that information contained in e-mail messages will become the property of Hamilton Health Sciences.

I understand that information contained in e-mail messages may be personal health information which may be used in decisions about my treatment or care and if used for this purpose, will be retained on my health record.

I understand that the Information and Privacy Commissioner (IPC) Ontario, does not support the practice of communicating personal health information by e-mail.

I agree to the following information being contained in e-mail correspondence _____

_____

_____ and to the

sensitivity of the subject matter as discussed with _____.
(Print name of HHS Staff or Physician)

I declare that I have read this information and understand it.

_____	_____	_____
(year / month / day)	Printed Name of Patient or Substitute Decision Maker	Signature of Patient or Substitute Decision Maker

* _____

* If substitute decision maker, specify relationship to patient **and complete information on reverse**

_____	_____
Printed Name of HHS Staff or Physician	Signature (and designation if applicable) of HHS Staff or Physician

(Provide patient / SDM with a copy of this consent upon completion)

Hamilton Health Sciences

CONSENT FOR E-MAIL CORRESPONDENCE

Date: (yyyy/mm/dd) _____

Patient's Last Name First Name

Address - Street City

HIN

Patient's Birth Date (yyyy / mm / dd) Age Gender ☐ M ☐ F

Family Physician

Substitute Decision Maker Identification

Name: _____

Address & Phone #: _____

_____

Relationship to Patient: _____

1. I am at least 16 years old or I am under 16 years and the parent of the incapable patient

2. I believe that the incapable patient, when capable, would not have objected to me communicating with Hamilton Health Sciences via e-mail correspondence.

3. I believe that no one ranking higher than me, or the same rank as me, claims authority and is available and willing to decide about communicating with Hamilton Health Sciences via e-mail correspondence.

Choose one of the following:

a) Court Appointed Guardian

b) Power of Attorney

c) Representative appointed by the Consent Capacity Board

d) Spouse or Partner

e) Parent of Child

f) Parent with a right of access

g) Brother or sister

h) Any other relative related by blood, marriage or adoption

Date _____ (yyyy/mm/dd) Signature of Substitute Decision Maker _____

(Provide patient / SDM with a copy of this consent upon completion)