



CONSENT FOR E-MAIL CORRESPONDENCE

Patient's Last Name	First Name	
Address - Street		City
HIN		
Patient's Birth Date (yyyy / mm / dd)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> 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
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* _____

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



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CORRESPONDENCE**

Date: (yyyy/mm/dd) _____

Patient's Last Name	First Name

Address - Street	City

HIN	

Patient's Birth Date (yyyy / mm / dd)	Age
Gender	<input type="checkbox"/> M <input type="checkbox"/> 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 _____ Signature of Substitute Decision Maker _____
(yyyy/mm/dd)

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

