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CONSENT FOR USE OF PATIENT'S E-MAIL ADDRESS

Welcome to my new office! I hope to enjoy practicing here for many years to come. I look forward to bringing my delivery of health-care into the twenty-first century. One of the firsts tasks we want to do is to compile a list of patients' email addresses. Many of you already correspond with me via electronic mail, and while not as immediate as the telephone, it certainly avoids "telephone tag." Email allows for exchange if information at a time that the recipient is ready and able to get it. I plan on a regular newsletter, probably three to four times a year with timely practice and medical information. I also want to be able to use the email (eventually, NOT now) to make and cancel appointments.

You may be aware that I prefer my staff to contact you (directly) by phone regarding lab and x-ray results. I believe that it is timelier and more personal than a postcard in the mail. However, as my practice grows, it is becoming more difficult. To help facilitate a more personal approach than postcards, I would like to be able to deliver results by email.

For those of you who are interested, please complete the bottom of the page regarding information about email. As with the rest of your medical records, all correspondences will be kept confidential.

Patient Name

Date of Birth

My email address is (please print)_____

Please ONLY use my email address for general medical and practice information, and for answering email from me, and not for the transmission of any personal information such as results.

I consent to allow Dr. Klein and/or his staff to email to me general medical and practice information, well as any or all of my lab and x-ray results, or other personal information pertinent to my care. I am aware that Internet email, although very secure, is not perfect, and theoretically others may have access to any information sent to me. I am also aware that other people may have access to my email, and that Dr. Klein and his staff is not responsible for any breech of privacy on my computer.

I may revoke this consent at any time by notifying Dr. Klein or his staff in writing.

Patient's (or Parent's) Signature

Date