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**PATIENT CONSENT FOR ELECTRONIC COMMUNICATIONS**

Full Name:      Email address:

Pharmacy Name and Location:

Pharmacy Phone Number:       Pharmacy Fax Number:

**Patient Consent for Electronic Contact**

I,       (name of patient) wish to communicate with my care provider through email and telemedicine consultations. I acknowledge and understand that these emails and video conferences are not encrypted on the hospital email system, and therefore, the office and hospital cannot guarantee the security of the messages that I send to or receive from my care provider.

I agree not to use email to communicate emergency or urgent health matters since email messages can be delayed for technical reasons beyond the control of my care provider. I understand my care provider may make decisions about my treatment based on information I provide through email and that this information will also form part of my health record if it is relevant to my care.

I acknowledge that at any time, I or my care provider can decide that we no longer wish to communicate through email or telemedicine conferencing. If I decide to stop communicating through email, I agree to inform my care provider in writing or at my next appointment. If my care provider cannot continue email communication with me, she will inform me in writing and /or notify me about this at the time of my next appointment.

By signing this Consent, I confirm I have read and agree to these terms.

Date signed:

Signature of Patient

(Can print name)