

**Internet Health Information Communication**  
**Consent Form**

Patient: \_\_\_\_\_ Account Number: \_\_\_\_\_

In connection with the medical services that I am receiving from Family Allergy & Asthma Consultants, P.A. (the P.A.), I hereby authorize the P.A. to disclose any and all information concerning my medical condition and treatment (including, but not limited to, super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence, or other such information), including copies of applicable hospital and medical records, to the following e-mail address:

\_\_\_\_\_:

I hereby assume full responsibility for the security and privacy of any communication delivered to me in accordance with the above and indemnify and hold the P.A. harmless from and against all claims associated with any breach of said communication's privacy and/or security by any third party.

I further understand and agree that the medical information transmitted is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of, or taking of any action in reliance upon, this information by persons or entities other than the intended recipient is prohibited. If I receive any communication in error, I will contact the P.A. and delete the material from any computer. Because e-mail can be altered electronically, I understand that the integrity and security of any communication cannot be guaranteed.

This consent is valid from the date executed until revoked in writing by the patient.

Signed: \_\_\_\_\_  
Date: \_\_\_\_\_  
Witness: \_\_\_\_\_

**Please log on to [www.jaxallergists.com](http://www.jaxallergists.com), go to eServices and click on 'Use eServices' and follow prompts to set up an account.**