



CONSENT FOR ELECTRONIC COMMUNICATION

Eterna MD Medical Rejuvenation Center

1307 South International Pkwy Suite 2091, Lake Mary FL 32746

Phone 4077710404 | Fax 4077710405 | info@eternamd.com | www.eternamd.com

Dr. Carlos Mercado MD has offered to communicate using the following means of electronic communication ("the Services") [check all that apply]:

____ Email

____ Videoconferencing

____ Text messaging (including instant messaging)

____ Website/Portal social media

____ Other (specify): _____

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for the use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Physician and the Physician's staff. I consent to the conditions and will follow the instructions outlined in the Appendix and any other conditions that the Physician may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk.

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

1- APPENDIX

Risks of using electronic communication

The Physician will use reasonable means to protect the security and confidentiality of information sent and received using the Services ("Services" is defined in the attached Consent to use

electronic communications). However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of electronic communications:

Patient Name: _____ **Date of Birth:** _____

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect electronic communication's privacy and security, it is impossible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communications can introduce malware into a computer system, potentially damaging or disrupting the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician or the patient.
- Even after the sender and recipient have deleted copies of electronic communications, backup copies may exist on a computer system.
- Electronic communications may be disclosed in accordance with a duty to report or a court order.
- Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.
- If the email or text is used as an e-communication tool, the following are additional risks: Email, text messages, and instant messages can more easily be misdirected, resulting in an increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the identity of the sender or to ensure that only the recipient can read the message once it has been sent.

2- APPENDIX CONTINUED

- Conditions of using the Services While the Physician will attempt to review and respond in a timely fashion to your electronic communication, the Physician cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time.
- The Services will not be used for medical emergencies or other time-sensitive matters.

Patient Name: _____ **Date of Birth:** _____

- If your electronic communication requires or invites a response from the Physician and you have not received a response within a reasonable time, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed.
- You are responsible for following up on the Physician’s electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care.
- The Physician might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
- You and the Physician will not use the Services to communicate sensitive medical information about matters specified below [check all that apply]:

____ Sexually transmitted disease

____ AIDS/HIV

____ Mental health

____ Developmental disability

____ Substance abuse

____ Other (specify):

- You agree to inform the Physician of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying the Physician in writing.
- Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.
- The Physician is not responsible for information loss due to technical failures associated with your software or internet service provider.

Patient Name: _____ **Date of Birth:** _____

3- APPENDIX CONTINUED

- Instructions for communication using the Services To communicate using the Services, you must: Reasonably limit or avoid using an employer’s or other third party’s computer.
- Inform the Physician of any changes in the patient’s email address, mobile phone number, or other account information necessary to communicate via the Services.
- If the Services include email, instant messaging, and/or text messaging, the following applies:
 - Include in the message’s subject line an appropriate description of the nature of the communication (e.g., "prescription renewal"), and your full name in the body of the message.
 - Review all electronic communications to ensure they are clear, and that all relevant information is provided before sending to the physician.
 - Ensure the Physician is aware when you receive an electronic communication from the Physician, such as by a reply message or allowing "read receipts" to be sent.
 - Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.
 - Withdraw consent only by email or written communication to the Physician.
 - If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on the Services. Rather, you should call the Physician’s office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.
- Other conditions of use in addition to those set out above:

I have reviewed and understand all the risks, conditions, and instructions described in this.

Patient name: _____

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____