Keiki Korner Pediatrics
E-Mail Authorization Concerning Office Communication

Patient Name(s):__________________________________DOB_________________________
Patient Name(s):__________________________________DOB_________________________
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Parents/Guardians wishing to utilize e-mail as part of the physician-patient relationship are required to review and sign this form. E-mail communication is not required, its use is entirely optional. Also be advised that the physician reserves the right to discontinue communicating by e-mail for any reason. Please fill and sign below:

I, _____________________________, as the parent or guardian of the above child
(Print your name)
(children) agree that I:

1. Understand the concept of email and how to access it.
2. Certify that the following email address(s) is accurate:
   Preferred:_______________________________Other:__________________________
   ____
3. Understand that I, or my designee, accept full responsibility for messages sent to or from this address.
4. Understand and acknowledge that internet communication is not encrypted and inherently insecure, there is no assurance of confidentiality through email correspondence.
5. Understand that the provider may limit the information they are willing to communicate by email.
6. Understand that all email correspondence may be forwarded to other providers, including providers not associated with Keiki Korner Pediatrics, for purposes of providing treatment.
7. Understand that the office will maintain confidentiality within internal office network systems, but will not guarantee patient confidentiality nor HIPAA compliance of facilities and systems outside the office and its control.
8. Agree to hold Keiki Korner Pediatrics and it's associates harmless from any and all claims or liabilities arising from or related to this request.

I acknowledge that I have read, understand and agree to the above.

____ ____________________
Signature Today's Date