



Protected Health Information (PHI) Risk Statement

I _____, understand and accept the risk of requesting protected health information via electronic/email format. I further understand that I am solely responsible for providing correct email information and the hospital will not be held accountable for information being released to the incorrect address.

Risk Factors include but are not limited to:

- Email being send to the incorrect address.
 - Email being captured electronically en route.
 - Other persons with access to your email account
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- I agree and understand the risks associated with releasing my protected health information.
 - I disagree and do not request to move forward with the release of my protected health information.

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____