E-MAIL RELEASE FORM

Lincoln Surgical GROUP, P.C.

575 S 70th Street, Suite 405 | Lincoln, NE 68510-2471 | Phone: 402.483.7825 | Fax: 402.483.7839

Date: _____

I, _____
(Name of Patient or Authorized Representative)

want to communicate via e-mail with Lincoln Surgical Group, P.C. on matters related to my health and/or my medical treatment. I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail.

I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for loss of confidentiality associated with such transmissions.

Name: _____
(Print Name of Patient or Authorized Representative)

Signature: _____
(Signature of Patient or Authorized Representative)

Witnessed by: _____
(Print Name)

Signature: _____
(Signature of Witness)

HIPAA E-Mail Release Form
Before sending any non-encrypted e-mail communications (including attachments) containing Protected Health Information to any recipient, ensure that this form has been signed and is on file. Provide a copy to the patient.