



KARALTA

general practice

Suite 1:03 Element, 200 Central Coast Hwy, Erina, NSW 2250

Ph: 02 4365 2983 F: 02 4365 2548 e:admin@karaltagp.com.au

I, _____ wish to communicate with Karalta General Practice and Dr. _____ by email.

My email address is: _____. Information will not be sent to an alternate address without a new consent being signed.

I am aware that email communication is not 100% reliable or secure, but I acknowledge that the doctors and their staff assured me that they make every effort to protect my privacy, and I wish to use email to communicate with them.

1. I am aware and agree that a hard copy of all email correspondence will be filed in my medical chart.
2. I agree to include my name, home or mailing address and telephone number in the body of all email sent to my doctors' office to ensure that they have an alternate means of contacting me.
3. I will limit my email to: ask e.g. routine, non-urgent medical questions, or prescription re-fills.
4. I agree to fill in the subject line of each email to alert the doctors and their staff of the purpose of my message. (E.g., REFILL; QUESTIONS; APPOINTMENT; etc.)
5. I will not email my doctor regarding emergencies, as I am aware that time-sensitive matters are not appropriate for email communication.
6. I will not communicate by email about information or questions related to 1) highly sensitive subjects such as HIV/AIDS or Sexually Transmitted Diseases; 2) questions or problems of a sexual nature; 3) alcohol or drug dependence or treatment; or 4) questions about my mental health.
7. If I do not get a response to my email within 24 hours, I will contact the doctors or their staff via other means.
8. I know I am responsible for following the medical advice the doctors convey to me by email.
9. I accept that if I fail to follow this agreement related to our email correspondence, that the doctors will limit my correspondence to more traditional means, such as the telephone and/or mail.
10. I request and authorize the doctors and their staff to communicate my routine negative lab results to me via email.
11. I have asked all the questions I had about the doctor's email policies and my questions were answered to my satisfaction. I understand the policies and agree to abide by them in full.
12. I agree to pay the doctors' fees for email communication if applicable, and agree that no Medicare Rebate will be available for any email communication.

Patients signature

Date

