LBC Women's Health and Wellness PC
36 Malaga Plaza, Suite 203
Palos Verdes Estates, CA 90274

PATIENT EMAIL COMMUNICATION CONSENT FORM

Patient Name: _____
Date of Birth: _____

I understand that my healthcare provider may communicate with me via email regarding my medical care, including appointment reminders, test results, and general health information.

I acknowledge and understand the following:

- Email is not always a secure form of communication, and there is a risk that my protected health information (PHI) could be accessed by unauthorized individuals.
- Emails may be stored on servers and devices that are not fully secure.
- My healthcare provider will make reasonable efforts to protect my information but cannot guarantee complete security of email communication.
- I should not use email for urgent or emergency medical concerns. For urgent issues, I will call the office or seek immediate medical attention.
- I am responsible for providing a current and accurate email address and for notifying the office if my email changes.
- I understand that email communication may become part of my medical record.

I consent to receive email communications from:

Practice Name: _____
Provider Name: _____

Patient Email Address: _____

Preferred types of communication (check all that apply):
[ ] Appointment reminders
[ ] Lab/test results
[ ] General follow-up
[ ] Billing/administrative information

I understand that I may withdraw this consent at any time by notifying the practice in writing.

Patient Signature: _____
Date: _____