PELVIC EXAM CONSENT

Patient name: _____ Date: _____

Written consent of the patient or the patient's legal representative or guardian is required prior to a medical examination. Part of your evaluation may include but is not limited to a breast examination as well as a pelvic examination including rectal examination.

A pelvic examination is defined by and includes an examination of the vulva, vagina, cervix, uterus, fallopian tubes, ovaries, uterus, rectum, or external genitalia, or pelvic organs using a combination of modalities, which may include, but not be limited to, the healthcare provider's gloved hand or instrumentation.

I understand and consent to a **"MEDICALLY INDICATED GYN EXAMINATION INCLUDING BUT NOT LIMITED TO A PELVIC EXAMINATION AND/OR RECTAL EXAMINATION"**. This may be performed by the doctor, physician assistant, and/or medical resident.

Patient Name: _____Date_____

Patient Signature: _____

Signature of Legal Representative or Guardian: _____
(If patient under the age of 18)

Witness Signature: _____

1900 Don Wickham Dr Suite 120 Clermont, Fl 34711 Phone: 352-241-7050 Fax: 352-241-7035

HIPAA- PATIENT CONSENT FOR USE OF ELECTRONIC COMMUNICATION

Patient's Name: _____ Date of Birth: _____

My signature below is authorizing and giving my consent for detailed messages to be left on an e-mail, a cellular device, a home machine or any other technological device.

E-mail Address:
Cellular Number:
Home Number:

- With my consent, **South Lake OB/GYN & Advanced Surgery** may mail, e-mail, text, call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items and any communication pertaining to my clinical care; including laboratory results, diagnostic results, among others.
- With my consent, **South Lake OB/GYN & Advanced Surgery** may disclose my PHI to any hospital, physician or surgery center to assist my TPO. These items may include laboratory results, diagnostic results, insurance items and any other health information pertaining to my treatment and care.
- I have the right to request that **South Lake OB/GYN & Advanced Surgery** restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions; but if it does, it is bound by this agreement.

I agree and offer no objection to the verbal release of protected health information to the person(s) listed below. I also authorize these persons to pick up prescriptions, notes or other medical information on my behalf.

Person:	Relationship to patient:
Person:	Relationship to patient:
Person:	Relationship to patient:

Patient Signature: _____ Date Signed: _____

Witness Signature: _____ Date Signed: _____

SOUTH LAKE OB/GYN & ADVANCED SURGERY

E-MAIL CONSENT FORM

Patient Name: _____Date: _____

Patient E-mail Address: _____Patient phone number: _____

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOU PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of an e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information send and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patients medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patients prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. **PATIENT RESPONSIBILITIES AND INSTRUCTIONS:**

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.
b. Inform Provider of changes in his/her e-mail address.
c. Confirm that he/she has received and read the e-mail from the Provider.
d. Put the patient's name in the body of the e-mail.
e. Include the category of the communication in the e-mails's subject line, for routing purposes (e.g. billing and questions).
f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
g. Withdraw consent only by e-mail or written communication to Provider.

4. **TERMINATION OF THE E-MAIL RELATIONSHIP:**

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and the consent to the conditions herein. I agree to the instructions outlined herein, as well as other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Name (print) _____

Patient Signature _____ Date _____

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and cost, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print) _____

Patient Signature _____ Date _____