DR JOHN P SALERNO

SALERNO WELLNESS

EMAIL CONSENT FORM

PREFERRED OFFICE LOCATION

☐ NY ☐ CT

I, _____, hereby consent to allow my physician, Dr. John P. Salerno, to communicate with me, members of his staff (where appropriate), or other healthcare professionals, including physicians, nurse practitioners, registered nurses, medical assistants, and pharmacists, via email regarding the following aspects of my medical care and treatment:

- Test results
- Prescriptions
- Appointments
- Billing
- Other relevant medical matters

I understand that email is not a secure or confidential method of communication. I acknowledge the risk that email correspondence between my physician, members of the physician's office staff, or other healthcare professionals may be intercepted by third parties or inadvertently transmitted to unintended recipients.

Additionally, I understand that any email communication regarding my medical care and treatment will be printed and included as part of my medical record.

I am aware that email is not an appropriate method for handling emergencies. In the event of an urgent or emergency situation, I will contact the provider directly or seek care at the nearest Emergency Room.

PATIENT'S NAME _____ DATE _____

PATIENT'S SIGNATURE _____

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