



CONSENT FOR COMMUNICATION

Patient Identification/label

I authorize CHEO and/or _____ to communicate via the following methods: _____
(Team/Department//Discipline/Health Care Professional)

- Email Communication (*Email:* _____) Video Conference Telephone
- Text/SMS (_____) Internet Based Platform _____
(Please specify)

Please read the following carefully:

Patients should not use email for urgent communications. Please note that email is not encrypted on the CHEO email system. Security and privacy can never be completely guaranteed.

As a patient/legal guardian/substitute decision maker, you are responsible for maintaining the privacy of your personal devices.

I acknowledge the health care professional’s right to, upon written notice, withdraw the option of communicating through telecommunications.

(Signature of Patient – 12 years and older)

Date: _____

(Substitute Decision Maker)

(Witness to Identification and Signature)

(Relationship to Patient)

CHEO Representative: _____
(Print Name)

(Signature)

Revoking of Consent for Communication

I no longer wish to communicate via: _____

(Signature of patient/legal guardian)

(Signature of Health Care Professional)

Date: _____

Date: _____