Main Floor, East Calgary Health Centre
4715 8 Ave SE
Calgary, AB T2A 3N4

Phone 403-955-1077
Fax 587-387-7060

**EMAIL CONSENT**

Many people use email as a convenient form of communication. However, email is not considered a secure form of communication, which is an important consideration when transmitting patient health information.

As a result, the Children's Health Clinic will not accept any form of email communication regarding patient care without prior consent from the parent/legal guardian. Any communication received without this consent will be immediately discarded. This form will allow patients and their families to give their consent to email forms, assessments, etc. to the Children's Health Clinic.

Email communication is for administrative purposes only.

Your child's pediatrician will not be responding to emails, including requests for medical diagnosis or information.

**As the parent/guardian, I acknowledge that email is not a secure form of communication and agree that the Children's Health Clinic will not be held accountable for any dissemination of information resulting from email communication.**

| | |
|---|---|
| ______________________________ | ______________________________ |
| Patient Name | Date of Birth |
| ______________________________ | ______________________________ |
| Parent/Guardian's Name | Parent/Guardian's Signature |
| ______________________________ | ______________________________ |
| Email Address | Date |

4715 8 Ave SE
Calgary, AB
T2A 3N4

# CHILDREN'S Health Clinic

Phone: 403-955-1077
Fax: 587-387-7060

## Please Print

**Patient**

First Name | Last Name | Date of Birth (dd/mm/yyyy) | Male / Female / Other

Street Address | City | Province | Postal Code

Primary Phone Number | Alternate Phone Number | Name of Family Doctor

E-mail Address | Health Care Number and Province

Grade and School/Daycare | Preferred Pharmacy and Location

**Parent/Caregiver 1**

First Name | Last Name | Relationship to Patient

Address the same as patient's address? Yes | No, please provide address and phone number below

**Parent/Caregiver 2**

First Name | Last Name | Relationship to Patient

Address the same as patient's address? Yes | No, please provide address and phone number below

Are parents together? Yes | No. Are custody documents available? No | Yes, please provide us with a copy

Are any of the patient's siblings a patient of the Children's Health Clinic? No | Yes, please provide their information below

First and Last Name | Date of Birth (dd/mm/yyyy)

First and Last Name | Date of Birth (dd/mm/yyyy)

Is Child and Family Services involved? No | Yes, please provide caseworker's information

First and Last Name | Phone Number

Location | Email Address

I AM AWARE THAT THE CHILD WILL BE SEEN IN CONSULTATION AND PRIMARY CARE IS NOT PROVIDED BY THE CHILDREN'S HEALTH CLINIC. ONCE THE REASON FOR THE REFERRAL HAS BEEN RESOLVED I MAY BY ASKED TO RETURN TO MY PRIMARY CARE PROVIDER. BY SIGNING BELOW, I CERTIFY THAT ALL INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

First and Last Name | Relationship to Patient

Date Signed

Signature

Clinic Use Only
Entered By: ____________________
Date Entered: ____________________
Chart #: ____________________
Initial: ________ Update: ______

Revised May 2024