

**CENTER FOR REPRODUCTIVE MEDICINE**

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**E-MAIL COMMUNICATION  
INFORMED CONSENT**

I, \_\_\_\_\_ (print patient name), understand that if I chose to use e-mail as a form of communication with my physician or his staff at CRM that CRM will make every reasonable attempt to maintain confidentiality, however, there are no guarantees that confidentiality can be maintained.

I understand that my physician or staff at CRM will only communicate with me at the address listed in the address bar as a reply.

I understand that I can only communicate with my physician as a reply at the address listed in the address bar.

I understand that the e-mail communications are limited to care and treatment pertaining to that particular treatment or treatment cycle.

I understand I can never e-mail in an emergency situation.

I understand the response time on an email may be 24 hrs.

I understand that I am responsible for requesting discontinuing e-mail communications.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date