PERMISSION FOR THE ELEANOR M. LUSE CENTER TO CORRESPOND BY EMAIL

Client Name: _____ DOB: _____

I _____ give my permission for the Eleanor M. Luse Center to communicate with me by email for the following items:

_____ Appointment Dates and Times

_____ Insurance Information

_____ Treatment Information

_____ Other: (Explain)

Email Address: _____

I understand the risks associated with unencrypted email include inadvertently sending information to someone other than you; unauthorized access of the sender's copy of email that has been sent to you; unauthorized or inadvertent forwarding by individuals who receive copies (cc, bcc) of messages addressed to you; interception of email in transit from the sender to you; and unauthorized access of email after it has been delivered to you. The same risks apply if you send, forward, or reply to email containing your PHI.

I understand that this is not completely secure and we will attempt to minimize the amount of personally identifiable information in our email correspondence to that which is necessary for effective communications.

_____ _____

Signature (Client/Parent/Guardian) Date