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Licensed Psychologist # 4360

REQUEST FOR CONFIDENTIAL ELECTRONIC COMMUNICATIONS

Name of Patient: _____

Date of Request: _____Date of Birth: _____

I request that the following communications from the practice be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold the practice responsible should such incident occur.

Communications

_____Appointment scheduling _____ Brief questions regarding treatment

_____ Other (list specifically): _____

Method

_____E-mail E-mail Address: _____

_____Text Phone Number: _____

Acknowledgement and Agreements: I understand and agree that the requested communication method is not secure, making my PHI at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against the practice in any way should this occur.

SIGNED: _____Date: _____

Print Name:_____Phone No.: _____

Address: _____

_____

Personal Representative: _____

Request Received By/Date: _____