ColumbiaDoctors

Patient Request for Unencrypted Email Communication

Patient Name:_____ **Date of Birth:** _____

Phone Number:_____ **Email Address**:_____

This form authorizes your provider/program to communicate with you via unencrypted email.

I understand that communications over the Internet or use of an email system may not be secure and there is no assurance of confidentiality when communicating via unencrypted email.

Please be advised that:

- **This request applies only to the healthcare provider or program stated below.**
  A separate form is required if you would like to request to communicate via unencrypted email with another health care provider or program.

- An email address must be provided

- A test email is recommended before corresponding via email.

I understand and agree to the following:

- The email address provided is accurate and I accept responsibility for messages sent to or from this email address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form.
- Communication over the internet or using unencrypted email may not be secure and there is no assurance of confidentiality of information communicated via unencrypted email.
- Email communications may be forwarded to other providers and documented in my medical record for my treatment.
- I have the right at any time to revoke this authorization by contacting my provider and informing them that I wish to revoked my authorization.
- I agree to hold ColumbiaDoctors and individuals associated with ColumbiaDoctors harmless from any and all claims and liabilities arising from or related to this request to communicate via unencrypted email.

_____ _____

Signature of patient **Date**

ColumbiaDoctors Psychiatry

Name of Physician or Program