Steven S. Schwartz, Ph.D. & Associates

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Clinical Psychologist

UNENCRYPTED EMAIL COMMUNICATION CONSENT FORM

As my patient, you may desire to communicate with me via unencrypted electronic mail (email). You do not need to sign this form if you wish to communicate via unencrypted email solely for the purposes of scheduling, billing, and to ascertain benefits and eligibility.

This Fact Sheet will inform you of the risks of communicating other, more *specific health information* with me via email. Your health is important to me and I will make every effort to reasonably comply with your request to receive communications via email; however, I reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your/your child's best interest.

PLEASE READ THIS INFORMATION CAREFULLY

I will make every effort to promptly respond to your requests for information via email; however, if you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention.

Risks of using email to send protected health information (PHI) include, but are not limited, to:

- Risk of Unauthorized Access by a 3rd Party: For example, sharing a computer, using email provided through an employer, accessing your email over an unsecured connection such as public Wi-Fi, and accessing email on your mobile device can result in unauthorized access by someone you do not wish to know about your health information. Furthermore, despite necessary precautions, email may be sent to the wrong address by either party or be intercepted or altered in transmission by a computer hacker or computer virus.

- Unique Difficulty in Verifying the Sender: Email may be easier to forge than handwritten or signed papers. I will only send emails to the email address you provide, but it may be difficult to confirm that you are the person sending the request for information from your email address.

Procedures

- Emails are not checked outside of my normal business hours; typically Tuesday-Thursday daytime hours.

• If at any time you change your email address or wish to discontinue email communications please notify me in writing.

7650 Rivers Edge Dr. Ste. 140 Columbus, OH 43235
T: (614) 578-0718 F: (614) 841-1957

PATIENT CONSENT TO UNENCRYPTED EMAIL COMMUNICATIONS

By signing below, you acknowledge your recognition and understanding of the inherent risks of discussing/sending your health information via unencrypted email and hereby consent to originate and receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion. By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone and postal mail. By signing below, you agree to hold Julie M. Canfield, Psy.D. LLC harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

_____ **I do wish to originate and/or receive my health information via unencrypted email.**

Client Name (printed): _____

Client Email Address: _____

Date of Birth: _____

Client Signature: _____
or Legal Guardian

Date: _____

If signed by someone other than the Patient, state your relationship to the Patient and a description of your authority to act on the Patient's behalf:_____

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_____ **I do <u>NOT</u> wish to originate and/or receive my health information via unencrypted email.**

Client Name (printed): _____

Client Email Address: _____

Date of Birth: _____

Client Signature: _____
or Legal Guardian

Date: _____

If signed by someone other than the Patient, state your relationship to the Patient and a description of your authority to act on the Patient's behalf:_____