

E-MAIL CORRESPONDENCE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our office offers **optional** e-mail correspondence to address after office hours questions and concerns regarding your mental health care including general inquiries about medications and treatment. The purpose of this option is **not to substitute** follow-up visits with the psychiatrist, but to serve as an alternate means of communication with your mental health care provider. In reply to your e-mail, you may sometimes be instead instructed to follow up in our office to address your concerns if the psychiatrist recommends so based on his professional medical opinion.

The contents of the psychiatrist's corresponding e-mails may include your personal health information. In relevance to your e-mail question or concern, this could include (but may not be limited to) your psychiatric diagnosis, prescribed medications, alcohol and drug history, and other medical diagnoses. Our office will **not** be held responsible for any individual who gains access to the contents of the corresponding e-mails regardless of the means by which it occurred.

If you are interested in our optional e-mail correspondence, complete the following appropriately. If not, **DO NOT FILL OUT THIS FORM.**

I, _____, agree to participate in the e-mail correspondence option. I certify that I have read and understand the above information. If I decide to change my decision to participate in this option I agree to do so by notifying our staff and completing the bottom of this form, dating it, and returning it to our office.

My e-mail address is _____@_____.

Signature

Date

I **no longer agree** to participate in the email correspondence option.

Signature

Date