PONZURIC learning solutions

Email Authorization

Authorization to Utilize Unencrypted Email to Communicate
Protected Health Information

Client's Name: ______________________________________

Client's Date of Birth: ______________________________________

Thank you for your request to communicate with me via email. I want to make sure you know that email communications between us are not encrypted and therefore are not secure communications. If you elect to communicate with me from your workplace computer, you also should be aware that your employer and its agents may have access to email communications between us. Finally, email communications may become a part of your child's client medical record. Incoming email communications will be reviewed and responded to as soon as possible. If you have not heard from me with a response and are concerned, I may not have received the message, please call me during regular business hours.

Email communication should never be used in the case of an emergency or for urgent requests for information.

If you agree to the foregoing terms, please indicate that by signing this form that you accept the terms and conditions outlined herein.

☐ ACCEPTED ☐ DECLINED

______________________________ ______________________________

Printed Name (Client – if over age of 13) Client Signature

______________________________ ______________________________

E-mail Address Date

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If you agree to have your parents be a point of contact via email, please indicate that by signing below.

☐ ACCEPTED – Please cc parent and me ☐ ACCEPTED - Please contact parent only ☐ DECLINED

______________________________ ______________________________

Printed Name (Client – if over age of 13) Client Signature

______________________________ ______________________________

E-mail Address Date

______________________________ ______________________________

Printed Name of Parent or Guardian Signature

______________________________ ______________________________

E-mail Address Date

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