

## Child and Adolescent Psychiatry Consulting (CAPC) Agreement to Communicate by Electronic Messaging

Secure electronic messaging is always preferred to insecure email for more sensitive PHI, but under specific circumstances, insecure email communication containing protected health information (PHI) may take place between a Child and Adolescent Psychiatry Consulting (CAPC) provider and a patient.

This email communication may be used if both parties agree on this communication method and this form is completed and signed by the patient or the patient's personal representative (if appropriate).

A copy of this form and all email communication will be filed in the patient's Medical Record and a hard copy of this form will be provided to the patient. This agreement is limited to communications using the email addresses listed below.

**Provider Awareness:**

Standard email is not a secure means of communication, so as the provider I will use the minimum necessary amount of protected health information when responding to your questions or communicating information to you.

**Patient Awareness:**

Please note that most standard email does not provide a secure means of communication. There is some risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone or fax is an always an alternative that is available to you.

By completing this form, the provider and I understand and are willing to accept the risks involved with insecure email communication of my protected health information.

Date: \_\_\_\_\_  
Patient's Name (print name): \_\_\_\_\_  
Patient's signature \_\_\_\_\_

Guardian's Name (if applicable) (print name): \_\_\_\_\_  
Guardian's Signature: \_\_\_\_\_

Email address for communication (print): \_\_\_\_\_

Provider's Name: Jenna Saul MD  
Provider's email address : [drjenna@drjenna.net](mailto:drjenna@drjenna.net)

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**Withdrawal of Agreement for Email Communication**

Should either party no longer wish to communicate via email please complete the form below and deliver in person or send by U.S. mail to the other party.

A copy of the form will be filed in the Medical Record.

I no longer wish to communicate via email.

Date: \_\_\_\_\_ Name (print name): \_\_\_\_\_  
Email address (print): \_\_\_\_\_  
Signature: \_\_\_\_\_

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**Change of address:**

If your email address changes, please complete the information form again, for your new email address.