Assurance
Healthcare & Counseling Center

Authorization to Email Protected Health Information

Although secure electronic messaging is preferred to unsecure email messaging for communication of protected health information, unsecure email communication containing sensitive health information can be sent between an Assurance Healthcare & Counseling Center (AHCC) provider and patient. If this form is completed and signed by the patient, then unsecure email communication regarding the patient's medical care and treatment may be used to transmit information between the patient and AHCC.

Authorize email communication

☐ I authorize the Assurance clinical staff to email me regarding the course of my medical care, treatment and diagnostic test results, excluding information concerning mental health, substance abuse and sexually transmitted disease.

☐ I further authorize the disclosure of information related to mental health, substance abuse and sexually transmitted disease.

Patient representative's email address (*please print*):

_____

Signature required on the next page

Change email address

☐ I am changing the email address to be used for communications with Assurance

New email address (*please print*)

_____

Signature required on the next page

Discontinue email communication

☐ I no longer wish to communicate via email **signature required on next page**

- I understand that any email transmission between my provider and me/the patient will become part of my medical record (which AHCC privacy policies still remain in affect). These email transmissions may be disclosed in accordance with future authorizations.
- I understand that I have the right to revoke this Authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information. I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this authorization.
- I understand that this Authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, membership or eligibility for AHCC benefits if I refuse to sign this Authorization.
- I understand that, once information is disclosed pursuant to this Authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the HIPAA privacy rule.

Alert for Electronic Communication

Patients and/or personal representatives who want to communicate with their health care providers by email should consider all of the following issues before signing an Authorization to Email Protected Health Information:

1. Email at AHCC can be forwarded, intercepted, printed and stored by others.
2. Email Communication is a convenience and is not appropriate for emergencies or time-sensitive issues.
3. Highly sensitive or personal information should only be communicated by email at the patient's discretion (i.e. HIV status, mental illness, chemical dependency, etc.)
4. Employers generally have the right to access any email received or sent by a person at work.
5. Staff other than the health care provider may read and process email.
6. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
7. Communication guidelines muse be defined between the clinician and the patient, including (1) how often email will be checked, (2) instructions for when and how to escalate to phone calls and office visits, and (3) types of transactions that are appropriate for email.
8. Email message content must include (1) the subject of the message in the subject line (i.e., prescription refill, appointment request, etc.) and (2) clear patient identification including patient name, telephone number and date of birth or patient identification / account number (if known) in the body of the message.
9. AHCC will not be liable for information lost or misdirected due to technical errors or failures.

I have read and understand the Alert for Electronic Communications and agree that email messages may include protected health information about me/the patient, whenever necessary.

_____ _____

Patient/representatives signature Date

_____ _____

Patients printed name Date of birth

_____ _____

Patient representatives name Relationship

please note that this Authorization is not valid unless completed in full. This Authorization will not expire unless revoked in writing

Patient ID / Account # (for administrative use only)_____