AUTHORIZATION TO UTILIZE UNENCRYPTED EMAIL/ TEXT MESSAGING TO COMMUNICATE PROTECTED HEALTH INFORMATION

Electronic mail (email) and text messaging are forms of communication that may be utilized between you and the providers. We want to make sure you know that unencrypted email and text communications are not secure communications. Washington University is not able to encrypt text messages. We do have the ability to encrypt email communication of protected health information. Encryption is the process of making information unreadable unless you have the password or key to decrypt the information. We will encrypt email communications unless you tell that you prefer us to use unencrypted email. If it is your preference that we not encrypt our email communications with you, please initial here: ______

If you elect to communicate from your workplace computer, you should be aware that your employer and its agents may have access to email communications between us. Email and text communications may become a part of your patient medical record and be accessible to my clinical support staff as needed for our operations.

Incoming email communications will be reviewed and answered as soon as possible. If you have not heard from your provider's office with a response and are concerned that your message was not received, please call the office during regular business hours. EMAIL COMMUNICATION SHOULD NEVER BE USED IN THE CASE OF AN EMERGENCY OR FOR URGENT REQUESTS FOR INFORMATION.

Washington University Physicians may use text messaging to remind you of upcoming appointments and/or care coordination activities if you have elected to receive reminders in this manner. We will limit information sent via text message to the minimum necessary. Washington University Physicians does not encourage text messaging for other purposes.

This authorization may be revoked at any time and must be done in writing. It is understood that the revocation will not apply to information that has already been released based on this authorization.

Authorization is valid while in treatment relationship with any of the Washington University providers or in the event of:____.

If you agree to the foregoing terms, please indicate your acceptance by your signature that you accept the terms and conditions outlined herein.

ACCEPTED: Signature of Individual________________________________Date_________

Printed Patient Name __________________________________ DOB ____/_______/_______

Authorized E-mail of Individual ____

Department of origination of authorization____