PSYCH ASSOCIATES OF MARYLAND, LLC
EMAIL AUTHORIZATION

I authorize Psych Associates of Maryland, LLC and its employed and contracted licensed health care providers and staff (collectively, the "Practice") to use email to communicate clinical information to me pertaining to mental health care services that I may receive from the Practice. I acknowledge and understand that the most secure method of communication is by telephone call; however, if I choose to communicate with the Practice by email, these communications may contain my personal and private medical information (including, but not limited to, my name, address, date of birth, types and dates of mental health care services received, medications, insurance coverage information, and/or test results).

I understand that although the Practice will take reasonable measures to attempt to protect the privacy of the contents of emails sent to me; the emails sent to me travel over the Internet. As a result, there is a risk that emails may be intercepted and read by unauthorized third parties. By choosing to communicate with the Practice via email, I assume this risk.

I acknowledge and understand the following as it relates to email communications:

1. Email is not appropriate for conveying information relating to urgent or emergency medical matters. If I am experiencing an urgent or emergency situation, I understand that I should dial 911 immediately.
2. If an email has not been answered within twenty-four (24) hours, I should call to make sure that it has been received and I may make an appointment to discuss the email.
3. I will not use email communications for discussion of sensitive or highly confidential issues. If there are specific types of information that I do not want included in emails, it is my responsibility to notify the Practice.
4. Certain other health care providers who are permitted access to my medical records (such as consulting health care providers) may have access to my email address and email message.
5. I, and not the Practice, am responsible for the security of emails sent from or stored on my computer, tablet, or phone.
6. My decision to allow the Practice to communicate with me by email is voluntary, and treatment is not conditioned upon my election to do so.
7. The Practice or I may stop email communications at any time for any reason.
8. I agree to notify the Practice when my email address changes.
9. I will not to hold the Practice responsible for damages resulting from its use of email or the failure of any of the Practice's information systems to facilitate email communications.
10. I understand that all emails related to my care, received or generated by the Practice, may be maintained in my medical record.

The Practice (email addresses ending in "@pamllc.us") may send clinical information by e-mail to me at:

Email Address:

The Practice may also communicate via email with the designated individual listed below:

Name:	Relationship to Patient:
Email Address:	

Patient Name:	Patient Signature:	Date: