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Authorization to disclose protected health information VIA EMAIL

NAME ______________________________ DATE OF BIRTH ______________________

HOME PHONE _______________________ CELL PHONE ________________________

ADDRESS _____________________ CITY ________________ ST ______ ZIP ______

This authorization covers protected health information (PHI) disclosed by Doctors Direct personnel to a patient or a patient's representative through email communication. It expires when the need to communicate via email is no longer necessary, when the patient changes his/her email address, or if the patient revokes it.

My signature at the bottom of this form is authorization for Doctors Direct to disclose health information of the above-named patient via email. It also confirms my understanding that:

- **Information sent via email is not considered secure. There is the possibility of re-disclosure of the PHI of the risk that it may be disclosed or seen by an unintended recipient, such as any person who has access to your email account. Re-disclosure may no longer be protected by law.**
- **I should not use email for any urgent or time-sensitive medical question or issue.**
- **Once transmitted, I am responsible for safeguarding the information I receive.**
- **I have the right to revoke this authorization at any time before information is disclosed by submitting a Revocation of Release of Medical Information statement. A revocation will not apply to information that has already been released as a result of this authorization.**
- **To initiate email communication, I will send an email from my email address to Doctors Direct staff. Doctors Direct can also initiate communication described herein based on my authorization of this form.**
- **I am responsible for notifying Doctors Direct of any email changes and completing a new form with the new email address that is authorized.**

I authorize Doctors Direct to use the following email address:

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Patient/ Representative Signature **Date**