ALLERGY & ASTHMA CENTER, P.C.

AUTHORIZATION TO EMAIL HEALTH INFORMATION

I authorize and direct Allergy & Asthma Center, P.C., (Practice) to send me my medical records—including, but not limited to, chart notes, scans, and billing-related information—and other protected health information via **unsecured** email at _____ (email address). I understand the email is unsecure while in transit between Practice and me. Practice does not and cannot ensure the information will not be lost, compromised, or hacked while in transit, and I knowingly accept this risk.

I have reviewed and I understand this Authorization. I also understand that the information emailed pursuant to this Authorization may no longer be protected under federal law if lost, compromised, or hacked in transit. Unless revoked earlier, this Authorization shall remain in effect until my death.

Dated _____, 20___

_____ Date of Birth: ____/____/____

(Print name)

_____

(Signature)

Practice will not condition our provision of services or treatment to you on the receipt of this signed authorization.

For Practice Use Only

We attempted to obtain written authorization to send unencrypted email to patient but could not because:

[ ] Patient was informed of and accepted risk orally.

[ ] Other: _____