Pediatrics East Of New York P.C.
Authorization To Disclose Health Information Via E-Mail
Office Email: kids@pedsoneast.com
Office Website: www.pediatricseastofny.com

Patient Name: _____ DOB_____

Street: _____

City: _____ ST: _____ Zip: _____

Phone: _____ **Cell:**_____

This authorization covers protected health information (PHI) disclosed by Pediatric East Of New York, P.C. personnel to a patient or a patient's representative through e-mail communication. It expires when the need to communicate via e-mail is no longer necessary, when the patient changes his/her e-mail address, or if the patient revokes it.

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To be completed by patient or patient's representative:
My signature at the bottom of this form is authorization for Pediatrics East Of New York, P.C. to disclose the health information of the above-named patient via e-mail. It also confirms my understanding that:

- Information sent via e-mail is not considered secure. There is the possibility of re-disclosure of the personal health information or the risk that it may be disclosed or seen by an unintended recipient, such as any person who has access to your e-mail account. Law may no longer protect re-disclosure.
- **I should not use e-mail for any urgent or time-sensitive medical questions or issues**
- 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 to the Privacy Office a Revocation of Release of Medical Information Form. A revocation will not apply to information that has already been released as a result of this authorization
- To initiate e-mail communication, I will send an e-mail from my e-mail address, containing my request for information, to the Pediatrics East Of New York, P.C. party at the e-mail address below
- I am responsible for notifying the Pediatrics East Of New York, P.C party listed below if my e-mail address changes and completing another authorization in order to communicate using a different address
- If I am communicating via e-mail about someone else, I attest that I am responsible for that person's care or payment and will indicate my relationship to the patient below
- Pediatrics East Of New York. P.C will not condition treatment or payment upon receipt of an authorization

The e-mail address I wish to use is: _____

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative who will use e-mail to communicate about this patient, please sign above and complete the following:

_____ _____
Print name Relationship to patient Date