Dear\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient/POA name)

You have requested that our clinical team communicate with you or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (alternate person) using a form of electronic communication including email or video-based call.

We are happy to accommodate your request. As a healthcare provider, we are obligated to protect the privacy of our patient’s in accordance with HIPAA, and this includes information transmitted electronically. We use a HIPPA compliant, internet-based video service for all calls and our email service is HIPPA compliant as well.

The purpose of this letter is to receive your authorization to use these forms of electronic communication. Also, to inform you that emailing through your email provider may not be a secured environment. This means that your medical information could be intercepted by a third party and we are not responsible for such potential breaches. Please sign below to acknowledge your understanding of this information.

If you have any further questions, please contact us. Thank you.

I validate receipt of letter and understand the risks associated with electronic communication:

Preferred email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/POA Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_