Caroline B Williams, PhD MP *Prescribing Clinical Psychologist*
2204 Brothers Rd, Ste. B, Santa Fe, NM 87505 *(ph) 505-819-0859 (fax) 505-570-4560*

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) OVER UNSECURED EMAIL

Name: _____ Date of Birth: _____

I am authorizing and requesting that Dr. Caroline Williams release confidential and protected health information (PHI) to me through un-encrypted email.

*I have been advised that this method of communication is not secure or confidential.

*I understand that once Dr. Williams sends confidential information by un-encrypted email, she no longer has control over who has access to this information.

*I have been advised that all emails are retained in the logs of internet providers of both the sender and the recipient. These logs are theoretically available for reading by the system administrator(s) of the internet service provider.

*I understand that any email that Dr. Williams receives from me and any responses that she sends will become part of my legal medical record.

*I have been advised of confidential alternatives to unencrypted email for exchanging information with Dr. Williams. These include: fax, phone, mail, physical exchange of information in person, and encrypted electronic messaging through Dr. Williams' portal.

Upon reviewing the above information, I still request that Dr. Williams send confidential records and/or PHI through un-encrypted email.

_____ _____

Signature Date