AINSWORTH INSTITUTE OF PAIN MANAGEMENT

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION VIA EMAIL

Name: _____ Date of Birth: _____/_____/_____

Home Phone #: _____ Cell Phone#: _____

Address: _____ City:_____ State:_____ Zip:_____

This authorization covers protected health information (PHI) disclosed by Ainsworth Institute of Pain Management (AIPM) 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 e-mail address, or if the patient revokes it.

My signature at the bottom of this form is authorization for AIPM 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. Re-disclosure may no longer be protected by law.
- I should not use email 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 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 AIPM party at the e-mail address below.
- I am responsible for notifying the AIPM 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.
- AIPM will not condition treatment or payment upon receipt of an authorization.

The email 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 _____