

Robin Sakakini, Psy.D.

Licensed Psychologist
PSY 25438

Client's Name: _____
Client's Date of Birth _____

Email Authorization Form
Authorization to Utilize Unencrypted Email to Communicate
Protected Health Information

Thank you for your request to communicate with me via email. I want to make sure you know that email communications between us are not encrypted and therefore are not secure communications. If you elect to communicate with me from your workplace computer, you also should be aware that your employer and its agents may have access to email communications between us. Finally, email communications may become a part of your client medical record. Incoming email communications will be reviewed and responded to as soon as possible. If you have not heard from me with a response and are concerned I may not have received the message, please call me during regular business hours.

Email communication should never be used in the case of an emergency or for urgent requests for information.

If you agree to the foregoing terms, please indicate that by signing this form you accept the terms and conditions outlined herein.

ACCEPTED

Printed Name

Signature

E-mail Address

Date

Printed Name

Signature

E-mail Address

Date

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DECLINED

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Signature

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Date

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Signature

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Date

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