Gwynne Kohl, PhD
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EMAIL COMMUNICATION AGREEMENT

Email communication provides for a fast and easy way to communicate for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-therapist relationship.

The following summarizes the information you need to determine whether you wish to supplement your experience in my practice by electronically communicating.

General Considerations

Email communication will be considered and treated by Dr. Gwynne Kohl, with the same degree of privacy and confidentiality as written medical records. Dr. Kohl will use reasonable means to protect the security and confidentiality of email sent and received. However, there are known and unknown risks that may affect the privacy of personal health care information when using email to communicate. These risks include, but are not limited to:

- Standard email communication services, such as Gmail, AOL, Yahoo and Hotmail are not secure. This means that the email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals
- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by unintended recipients without my knowledge or agreement.
- Email may be sent to the wrong address by any sender or receiver.
- Email is easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread computer viruses.
- Email delivery is not guaranteed.

Patient Responsibilities

- **Email messages should not be used for emergencies or time sensitive situations.** In the event of a medical emergency, you should **immediately call 911.** For emergent or time sensitive situations, you should contact my practice by phone (206-550-1998).
- Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via email.

- Please acknowledge that you received and read the message by return email to Dr. Kohl.
- I understand that it is my responsibility to follow up with Dr. Kohl if I have not received a response to my email within a reasonable time period.
- I understand that, as stated in the Disclosure and Policy Statement and Agreement to Pay for Professional Services, that I will **be charged $15 for emails in which clinical issues are discussed.**

I have read and understood the above description of the risks and responsibilities associated with electronic communication with Dr. Kohl.

I acknowledge that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.

I have been given the opportunity to discuss electronic communication with Dr. Kohl and have had all my questions answered.

In consideration for my desire to use electronic communication as an adjunct to in-person office visits with Dr. Kohl, I hereby consent to electronic communication via non-secure email services.

I give permission for Dr. Kohl to send email messages that include patient health care information.

I understand that email messages she sends or receives regarding the patient may be included in the patient's chart.

I understand that I may revoke my consent to communicate electronically at any time by notifying Dr. Kohl in writing at the address above, but if I do, the revocation will not have an affect on actions Dr. Kohl has already taken in reliance on my consent.

I agree and release my provider and her practice from any and all liability that may occur due to electronic communication over a non-secure network. I further agree to be held accountable and to comply with the patient responsibilities as outlined in this agreement.

PATIENT Over 13 Years Old

_____ Patient Authorized Email Address

_____Patient Name (Print)

_____ _____

Patient Signature Date

PARENT (if applicable)

_____ Parent Authorized Email Address

_____ Parent Name (Print)

_____ _____

Parent Signature Date