

Request for Unencrypted Email Form

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(first name last name) (mm/dd/yy)

Printed name of client's representative: \_\_\_\_\_ Relationship: \_\_\_\_\_

**SECURE EMAIL COMMUNICATIONS** Child and Family Development sends email containing Protected Health Information (PHI) in a secure encrypted format.

**REQUEST FOR UNENCRYPTED EMAIL COMMUNICATION** On occasion, a client may request to receive information by an unsecure and unencrypted email method. In those instances, communication is intended for brief exchange of information with limited disclosure of PHI.

**CHECK ALL (4) BOXES TO INDICATE CONSENT AND UNDERSTANDING**

- ☐ I understand that Protected Health Information (PHI), such as names, addresses, phone numbers, and insurance information could be read or otherwise accessed by a third-party while in transit. Privacy and security are not guaranteed. Emails may be forwarded, intercepted, stored and changed. Emails are indelible, as known or unknown back-up copies may be stored on a computer or cyberspace. I understand these risks and accept responsibility associated with unsecure email communications.
- ☐ I understand that unencrypted emails from Child and Family Development will contain minimum information necessary and will be de-identified as much as possible.
- ☐ I understand that unencrypted emails are only sent to my personal email address(es).
- ☐ I understand that Child and Family Development is not liable for any difficulties related to unsecure transmissions, including but not limited to technical failure and transit loss.

**EXCHANGE OF INFORMATION**

|                                                                                                  |  |
|--------------------------------------------------------------------------------------------------|--|
| Personal email address:                                                                          |  |
| Exchange information pertaining to appointments/ scheduling (indicate yes or no)                 |  |
| Medical Records (Requested documents must be specified. List the name and date of the document.) |  |

X

Signature of client or client's representative

Date