EMAIL AUTHORIZATION FORM

By completing this form and emailing it back to Central Florida Pediatrics, you are giving your consent for protected health information (PHI) to be sent electronically. Email communication is a convenience and not appropriate for emergencies or time-sensitive issues. Employers generally have the right to access any email received or sent by a person at work. This method of information exchange is not secure once the information leaves our servers and is transmitted via the Internet.

AUTHORIZATION TO OBTAIN RECORDS VIA EMAIL

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

RECORDS RELEASE TO:

Name: _____

Email address: _____

Relationship to patient: _____

Specific Documentation Requested: _____

Purpose/Need for information: _____

Records requested from dates: _____ to _____

Signature: _____ Date: _____

Print name: _____ Relationship: _____

Contact phone number: _____

CONFIDENTIALITY STATEMENT

The information contained in this e-mail is legally privileged and confidential information intended only for the use of the individual or entity to whom it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any viewing, dissemination, distribution, or copy of this e-mail message is strictly prohibited. If you have received and/or are viewing this e-mail in error, please immediately notify the sender by reply e-mail, and delete this e-mail from your system. Thank you.