ColumbiaDoctors

Patient Name: _____

Date of Birth _____

Patient Request for Unencrypted Communication

This form authorizes your provider/program to communicate with you or specified others via unencrypted communication. **Please check all options that apply**:

☐   To allow unencrypted email communication

☐   To allow unencrypted text messages

☐   To allow unencrypted email communication with someone else (e.g., child's school, spouse, parent)

Specify **name and relationship** _____

Please be advised that:
- **This request applies only to the healthcare provider or program stated below.**
- **A separate form is required to request unencrypted communication with another health care provider or program.**
- For unencrypted email correspondence, an email address must be provided.
  - A test email/text message is recommended before corresponding via email or text message.

I understand and agree to the following:
- I understand that I am not required to sign this authorization and if I do not sign this form my providers will only communicate with me using the patient portal (i.e. CONNECT) or encrypted email.
- I understand that communication over the internet, using unencrypted email, or via text message may not be secure and there is no assurance of confidentiality when communicating via unencrypted messages.
- The email address/phone number **provided below** is accurate and I accept responsibility for messages sent to or from this email address/phone number.
- Communications may be forwarded to other providers and may be documented in my medical record for my treatment.
- I have the right at any time to revoke this authorization by contacting my provider and informing them in writing that I wish to revoke my authorization.
- I agree to hold ColumbiaDoctors, and individuals associated with ColumbiaDoctors harmless from all claims and liabilities arising from or related to this request to use unencrypted communications.

_____   _____

Signature of patient/guardian   **Date**

_____

Name of clinician or program treating patient

_____   _____

Contact name   **Contact information (email and/ or phone number)**

_____   _____

Contact name   **Contact information (email and/or phone number)**