REQUEST AND AUTHORIZATION TO EMAIL
PROTECTED HEALTH INFORMATION

By signing below, you acknowledge that you understand the inherent risks involved with sending and receiving information in an unencrypted, unsecured, format (such as regular email or unencrypted disc), and you agree to accept these risks. Such risks include misdirected messages, email intrusion, interception, or views by unauthorized parties. Additionally,

1. This Request applies only to Levitt Eye Care. If you would like to request to communicate via e-mail with another healthcare provider or office, you must complete a separate request for that office.
2. Florida Pediatric Associates does not recommend communicating health information that is sensitive in nature and that is provided additional protections under state and federal law (e.g., HIV/AIDS information, substance abuse treatment records information, mental health information, social security numbers, credit card information) via email.
3. This form only pertains to general communications. To request copies of your medical records, please contact the Florida Pediatric Associates office where you are being treated to submit your request in writing via the Request for Access to Protected Health Information Form.
4. Your request is not effective until you receive and respond appropriately to a test e-mail from us to verify your email account. Please select the test question you want to use below and provide us with your answer.

I would like to communicate via _____ secure, encrypted email _____ unencrypted (unsecure email)

Please provide the following information:
Patient name: _____ Date of birth: _____
Phone #: _____
Address: _____
Please specify the e-mail address to which communications should be addressed:
_____
Please specify the healthcare provider from which you are requesting e-mail communications:
_____

Please select the question you want to use (by checking one of the boxes below) for your test e-mail and provide your answer.
__ My mother's maiden name:_____
__ My middle name: _____
__ The street number of my residence: _____

Please initial each blank above and sign below:

_____ _____
Patient/Representative Signature Date

_____ _____
(relationship to patient if not patient) Telephone #