Email Disclosure

PROVIDER/PATIENT EMAIL ACKNOWLEDGEMENT/PERMISSION

I have read the *Provider/Patient Email/Information and Disclosure Form* and understand that communications over the Internet and/or using the email system are not encrypted and are inherently insecure. I understand that there is no assurance of confidentiality of information when communicated this way.

I understand that Diablo Valley Child Neurology, Inc. cannot prescribe medicine or schedule appointments by email. Health information that is especially protected under state and federal law (e.g., HIV/AIDS information, substance abuse treatment records information, mental health information) will not be communicated via email.

The email address(es) I give permission for Diablo Valley Child Neurology, Inc. to use is/are:

I accept full responsibility for any message sent to and from the above named email address(es).

I understand that all email communications in which I engage may be forward to other providers, including providers not associated with my doctor, for the purpose of providing treatment to my child.

I agree to hold my doctor and individuals associated with him/her harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

Signature: Date: