

AUTHORIZATION TO EMAIL/TEXT PROTECTED HEALTH INFORMATION

Name: _____ DOB: _____

Electronic mail and text messaging are forms of communication that may be utilized between Sunah Kim, Psy.D. and you. Please note that email and text communication are not secure communications. I cannot encrypt text messages, but I will send sensitive health information via encrypt email. Of note, encryption is the process of making information unreadable unless you have password to decrypt the information.

ALERT: If you elect to communicate from your workplace computer, you should be aware that your employer and its agents may have access to email communications between us. Email and text communications may become a part of your medical record. Email communication should never be used in the case of an emergency or for urgent requests for information.

I authorize Sunah Kim, Psy.D. to communicate with me via email, excluding my treatment/assessment records and other sensitive health information.

I authorize Sunah Kim, Psy.D. to communicate with me and send me attachment files including sensitive health information via encrypt-emailed email (skimpsyd@protonmail.com). I understand that file names will not include identifiable information, and files are encrypted and unmodifiable.

I authorize Sunah Kim, Psy.D. to communicate with a third party and send my health information via encrypt-enabled email (skimpsyd@protonmail.com). I understand that file names will not include identifiable information, and files are encrypted and unmodifiable.

* The written form of authorization to release information should be signed by me prior to this authorization.

I authorize Sunah Kim, Psy.D. to text me to remind me of upcoming appointments and/or care coordination activities. I understand that she will limit information via text to the minimum necessary.

EXPIRATION OF THIS RELEASE

Date: _____

If no date is indicated, the authorization will expire upon termination of services provided by Sunah Kim, Psy.D.

Client/guardian/representative Signature

Date:

Print Name

Relationship to client

NOTICE: Sunah Kim, Psy.D. and many other organizations and care providers are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect your health information.

YOUR RIGHTS: The authorization to release information is voluntary. This authorization may be revoked at any time. The revocation must be in writing, signed by you or you/guardian/or representative, and delivered to Sunah Kim, Psy.D. The revocation will take effect immediately upon the recipient of your signed form. You are entitled to receive a copy of the authorization.