Your Family Psychiatrist

Election Regarding Electronic and Telephonic Communications

For purposes of this communications election, the use of the word "office" should be taken to mean Your Family Psychiatrist, PLLC. In all cases where the word "you", "I" or "patient" is used, it should be taken to mean "the patient or their parent/legal guardian".

Your Family Psychiatrist, PLLC has a legal duty to safeguard your protected health information (PHI"). PHI includes information created or noted by this office that can be used to identify you and indicate that you have received, or are receiving, health care services. The office policies allow Your Family Psychiatrist to communicate with you via telephone, email and other electronic media regarding matters related to your care. However, PHI can be inadvertently disclosed to third parties if you do not have a private and secure means of receiving communications from this office (*e.g.*, a personal cell phone or computer device).

Acknowledgement

I have provided Your Family Psychiatrist with my email address and/or telephone number, and I acknowledge that I am responsible for keeping my email address and/or telephone number updated. (More than one option below may be completed.)

I elect to only receive PHI at the following email address: _____

I elect to only receive PHI as a text to the following number: _____

I elect to only receive PHI as a voice message/call at the following number: _____

I elect to only receive PHI in a live conversation at the following number: _____

I understand that I may elect to OPT OUT of all electronic and telephonic communications from Your Family Psychiatrist by placing my initials here: _____. (**NOTE**: If you elect to opt out of all electronic and telephonic communications, you must complete and submit another election form to receive return emails or texts, or telephone callbacks.)

_____ _____

Name of Patient or Legal Guardian (please print) Date

_____ _____

Signature Relationship to patient