Psychiatric Consultants, Inc.

AUTHORIZATION FOR E-MAIL CORRESPONDENCE

Email Address: _____

Only the patient is authorized to sign this form otherwise it represents a violation of the client privacy rights.

By signing this form I authorize Dr. Baez and staff to communicate by electronic mail (e-mail) with me.

I hereby release Dr. Baez and staff from any and all liability that may arise from the release of information as I have directed.

Email correspondence will be limited to appointment and general items as cancellations, finances, instructions and passwords, etc. The practice will not share clinical information via email unless done via your secure electronic medical record.

This authorization expires automatically a year after date signed.

I have read and understand the information in this form.

Date:_____

Patients Name: _____

Signature:_____