Deborah L. Smith, Ed.M. / LMHC

Patient Name: _____ **Date of Birth:** _____

Responsible Party (if different from parent): _____

I authorize Deborah L. Smith Counseling (DLSC) to email information to me upon my request. I understand that only general information will be communicated to me by email. Any information deemed sensitive or private by staff at DLSC or the provider will be communicated by phone or person only. Any communication by email will become a part of my permanent record at DLSC.

I understand that email communication is not secure and any other member of my household with shared email accounts may view my personal email. I understand that it is my responsibility to check my email and that DLSC is not responsible for email that does not reach my email address.

I understand that email is not to be used for any issue that require a response timelier than three business days. This includes clinical crises, prescriptions and appointment cancellations. Telephone remains the default mode of communication.

I understand that requesting the professional services of any DLSC staff to engage in email interchange for purposes such as for consideration of my specific clinical issues, for giving of clinical recommendations, for educational discussions, or for professional opinions, **may incur a fee that will NOT be covered by insurance.**

I understand that information will only be emailed to the address below, and that I will inform DLSC should the email address change by requesting and filing out a new form. I understand that I may reverse this authorization in writing to DLSC requesting the removal of my email address from my records.

Email Address: _____

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Patient or Responsible Party Signature Date

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Kennewick, WA 99336
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