Park Ridge Psychological Services

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I understand the Notice of Privacy Practices for Park Ridge Psychological Services and understand that it can be accessed at www.prpsych.com.

AGREEMENT FOR ELECTRONIC COMMUNICATION

Secure electronic messaging is always preferred for more sensitive protected healthcare information, but under some circumstances, insecure electronic communication containing protected healthcare information may take place between a Park Ridge Psychological Services provider and a patient. This communication may be used if both parties agree on this communication method, and if this form is completed and signed by both the provider and the patient or the patient's personal representative.

There is some risk that electronic communication, including texts and e-mails may be disclosed or intercepted by unauthorized third parties. By completing this form the provider and I understand this fact and are willing to accept the risks involved with insecure electronic communication of protected health information.

This agreement may be terminated at any time by written notification.

Client/Parent e-mail address _____

_____ _____

Client Name **Date of Birth**

_____ _____

Signature of client (or guardian) **Signature of Clinician**

Date of signing: _____/_____/_____

This form will be retained in your medical record.