GEOFFREY TAYLOR, M.D.

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AUTHORIZATION FOR NON-SECURE COMMUNICATION VIA EMAIL OR TEXT MESSAGE

PATIENT NAME ____

EMAIL ____

TELEPHONE (__________) ___________ - __________________

I request to communicate with my provider via unencrypted email, telephone, or text. I understand that communications over the internet or use of an email system may not be secure. There is no assurance of confidentiality when communicating via email.

I understand and agree to the following:

- The email address provided is accurate and that I accept full responsibility for messages sent to or from this address.
- I understand that communications over the internet or use of an email system may not be secure. There is no assurance of confidentiality when communicating via email.
- I understand that email communications may be forwarded to other providers only for the purposes of providing treatment to me.
- I have reviewed Dr. Taylor's Communication and Privacy Notice and understand that email and text message may only be used for administrative purposes.
- I agree to hold Geoffrey Taylor, MD harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

I provide this authorization until (Choose One)

☐ DATE _________/_________/_______________

☐ When I end treatment with Dr. Taylor.

I understand and agree to the above terms and conditions.

____
Signed

____
Print

_________/_________/_______________
Date