

# PICO

## Family Chiropractic Center

### HIPAA NOTIFICATION ELECTRONIC MAIL (EMAIL) COMMUNICATIONS

*The goal of Pico Family Chiropractic Center DC, PC is to make communication between you and our office as easy for you as possible. As such, you have the right to request that we communicate with you via electronic mail (email). However, prior to consenting to such communication, please take a moment to realize any and all privacy risks associated with this form of communication.*

Email communications are two-way communication. However, responses and replies to emails sent to or received by either you or, Pico Family Chiropractic Center DC, PC may be hours or days apart. As such, acute conditions should never be addressed using email communications.

Although Pico Family Chiropractic Center DC, PC, will make every effort to maintain privacy, email messages, on any device, have inherent privacy risks, as there is no way to ensure an email is completely tamper-resistant. That being said, you should not use email to discuss anything you wish to remain entirely confidential. In order to forward and/or process and/or respond to your email, individuals at Pico Family Chiropractic Center DC, PC, other than the intended recipient, may have access to or read your email message. Please remember, email communication is not a means of private communication.

This document, along with any and all email communications, may become part of your Pico Family Chiropractic Center DC, PC, medical record.

#### PATIENT REQUEST FOR EMAIL COMMUNICATION

*Please complete the information below if you wish to communicate Pico Family Chiropractic Center DC, PC, via email, knowing there are inherent privacy risks.*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_

*Please initial each line and sign below:*

\_\_\_\_\_ The email address contained herein is accurate, and I accept full responsibility for messages sent to or from this address.

\_\_\_\_\_ I have read, reviewed, and received a copy of this HIPAA Notification: Electronic Mail Communications.

\_\_\_\_\_ I understand and acknowledge that there are inherent privacy risks when communication is over the Internet.

\_\_\_\_\_ I agree to hold Pico Family Chiropractic Center DC, PC, and its agents and representatives harmless from any and all claims and liabilities arising from or related to this Request for Email Communication.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgment of Receipt  
NOTICE OF PRIVACY PRACTICES**

By signing and dating this form, I acknowledge that I have received a copy of Pico Family Chiropractic DC, PC's Notice of Privacy Practices.

Patient's Name <i>(Please print)</i>	Last four digits of your Social Security #
Patient's Signature	Date

If executed by a patient's personal representative, please complete the information in the space below:

Personal Representative's Name <i>(Please print)</i>	Relationship
Personal Representative's Signature	Date

If executed by a patient's legal guardian, please complete the information in the space below:

Legal Guardian's Name <i>(Please print)</i>	Relationship
Legal Guardian's Signature	Date