

The Office of  
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### Authorization to E-mail Protected Health Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to transmit the following to me via e-mail communication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My e-mail address is: \_\_\_\_\_

This is (circle one)  Single communication       Continuing authorization for 12 months

E-mail is a non-secure means of communication, and I understand that there is a remote possibility that such communication could be intercepted and interpreted by another person. By signing this authorization, I accept those risks and release Ellen Dye, Ph.D. from any legal responsibility or liability for disclosures that may occur as a result of illegal interception of the subject e-mail communications by others.

I understand that I may revoke this authorization in writing at any time except to the extent that communications have been made prior to my revocation in reliance on this authorization and that such communications shall not constitute a breach of my right to confidentiality.

To insure maximum confidentiality, it is best to keep e-mail communications brief and to primarily address practical matters such as scheduling. E-mail should not be used as a means of seeking clinical feedback or in case of emergency. Client information included in e-mails should ideally be restricted to information you would be comfortable having as public knowledge.