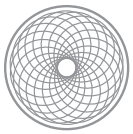


Westside Therapy

Leah DeSole, Ph.D.

Email Consent Form

210 West 70th Street, Suite 001
New York, NY 10023
(917) 757-5422
drdesole@westside-therapy.com

This form is used to obtain your consent to communicate with you by email regarding your protected health information (PHI).

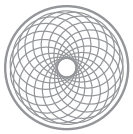
Dr. DeSole offers patients the opportunity to communicate by email. In order to request communication by email, you must complete this form and return it to Dr. DeSole. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Communications over the Internet and/or through email may not be encrypted and may not be secure. There is some risk that any PHI contained in email may be disclosed to or intercepted by unauthorized third parties. Therefore, there is no absolute assurance of confidentiality when communicating via email.

Dr. DeSole will use reasonable means to protect the security and confidentiality of email information sent and received. Dr. DeSole will use the minimum necessary amount of PHI when responding to your questions or communicating information to you. However, Dr. DeSole cannot guarantee the security and confidentiality of email or SMS communication (text messages) and will not be liable for inadvertent disclosure of confidential information.

Patient's Acknowledgment and Agreement:

I acknowledge that I have read and fully understand this consent form and agree to the following:

- I understand and am willing to accept the risks associated with communication by potentially insecure email between Dr. DeSole and myself and any questions I may have had were answered.
- I certify the email address provided on this request is accurate and that I accept fully responsibility for messages sent to or from this address. This agreement is limited to the email address(es) provided below.
- I have received a copy of the Important Information about Patient Email form and I have read and understood it.
- I understand and acknowledge that communications over the Internet and/or through email may not be encrypted and may not be secure, so there is no assurance of confidentiality of information communicated in this manner.
- I understand that all email communications in which I engage may be forwarded to other providers for purposes of providing treatment.
- I agree to hold Dr. DeSole harmless from any and all claims and liabilities arising from or related to this request to communicate via email.
- I agree to all the conditions outlined herein and consent that Dr. DeSole may communicate with me regarding my protected health information by email.



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Patient Name: _____ DOB: ____ ____ ____

Patient (or authorized representative) Signature: _____

If Representative, Relationship to Patient: _____ Date: ____ ____ ____

Patient/Authorized Representative Email Address: _____

Patient/Authorized Representative Phone: ____ ____ ____

Provider Name: _____

Provider Email Address: _____

Date: ____ ____ ____

Withdrawal of Agreement for Email Communication:

Should either party no longer wish to communicate via email, please complete this form below and deliver in person or send by U.S. mail to the other party. A copy of this form will be filed in the medical record.

☐ I no longer wish to communicate via email

Date: ____ ____ ____

Patient Name: _____ DOB: ____ ____ ____

Patient (or authorized representative) Signature: _____

If Representative, Relationship to Patient: _____ Date: ____ ____ ____

Patient/Authorized Representative Email Address: _____