E-MAIL COMMUNICATION CONSENT FORM

I, consent to the use of e-mail communication between myself, Dr. Sackheim and her office staff. This communication may include prescription refill requests, test results, and information regarding appointment changes or confirmations as well as medical records. Dr. Sackheim's office staff has informed me the e-mail system is HIPAA compliant and safe to communicate my personal information. I understand that I may withdraw my consent to communicate via e-mail with Dr. Sackheim and her office staff at any time in writing.

E-MAIL ADDRESS: ____

PRINT NAME: ____

SIGNATURE: ____

DATE: ______________________________