



CROSSROADS COUNSELING & CONSULTING ASSOCIATES, PC

Psychiatry, Mental Health and breakthrough TMS Treatment

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CONSENT TO PATIENT COMMUNICATION VIA EMAIL

Email is a quick and useful method of correspondence however; transmitting confidential information by e-mail can create a number of risks, both general and specific that patients need to be aware of if they choose this method of correspondence.

A. General email risks include but are not limited to the following:

- Email can be immediately broadcasted worldwide and received by many intended and unintended recipients;
- Recipients can forward email messages to other recipients without the original sender's permission or knowledge;
- Users can easily send an e-mail to the incorrect address;
- Email is easier to falsify than handwritten or signed documents;
- Backup copies of email may exist even after the sender or the recipient has deleted his or her copy;
- Without the benefit of face-to-face interaction, emails can be misinterpreted in tone and meaning.

B. Specific email risks include but are not limited to the following:

- Email containing information pertaining to a patient's diagnosis and/or treatment must be included in the patients' medical records. Thus, all individuals who have access to the medical record will have access to the email messages
- If you are sending your emails from your employer's computer, your employer does have access to your emails.
- Although CCCA (Crossroads Counseling and Consulting Associates, PC) representatives will endeavor to read and respond to email correspondence promptly, they cannot guarantee that any particular email message will be read and responded to within any particular time frame.

C. Conditions for use of Email

Reasonable means will be used to protect the security and confidentiality of the email. Because of the risk outlined above the security and confidentiality of email cannot be guaranteed. Your consent to email correspondence includes your understanding of the following conditions:

- All emails to and from you concerning your personal health information (PHI) will be a part of your file and can be viewed by health care and insurance providers and CCCA administrative and clinical staff.
- Your email messages may be forwarded within the CCCA between members as necessary for diagnosis, treatment, and reimbursement. However, they will not be forwarded outside CCCA office without your consent or as required by law.
- Though all efforts will be made to respond promptly this may not be the case. Because the response cannot be guaranteed *please do not use email in a medical emergency.*
- Medical information is sensitive and unauthorized disclosure can be damaging. You should not use email for communications concerning diagnosis or treatment of AIDS/HIV infection, other sexually transmissible diseases, mental health, and developmental disability or substance abuse issues.

• Since employers do not observe employees' right to privacy in their email system, you should not use their employer's email system to transmit or receive confidential emails.

• You are responsible for protecting your password and access to your email account and any email you send or you receive from CCCA to ensure your confidentiality. Your representative at CCCA cannot be held liable if there is a breach of confidentiality caused by a breach in your account security.

• Any email that you send that discussed your diagnosis or treatment constitutes informed consent to the information being transmitted. If you wish to discontinue emailing information, you must submit written consent or an email informing your CCCA representative that you are withdrawing consent to email information.

• Crossroads Counseling and Consulting Associates, PC will take reasonable steps to ensure that all information shared through emails is kept private and confidential. However, Crossroads Counseling and Consulting Associates, PC is not liable for improper disclosure of confidential information that is not a result of our negligence or misconduct.

Patient Name: _____

Patient Signature: _____ Date: _____

Authorized email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____

Cell: _____

If patient is a minor please complete:

Patient Name: _____

Parent/Legal Guardian Signature: _____

Relationship to patient: _____ Date: _____

Authorized email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____

Cell: _____

Please notify administrator if you wish to have the copy of this form returned to you after your visit.