Debra S. Guthrie, M.D.
*****PLEASE PRINT CLEARLY*****

Patient Name: _____

Email Authorization Form
Authorization to Utilize Unencrypted Email to Communicate
Protected Health Information

Thank you for your request to communicate with Debra S. Guthrie MD and staff via email. We want to make sure you know that email communications between us are not encrypted and therefore are not secure communications. If you elect to communicate with Debra S. Guthrie, MD from your workplace computer, you also should be aware that your employer and its agents may have access to email communications between us. Finally, email communications may become a part of your patient medical record and be accessible to my support staff as needed for our operations.
Incoming email communications will be reviewed and responded to as soon as possible. If you have not heard from me with a response and are concerned we may not have received the message, please call the office during regular business hours.

Email communication should never be used in the case of an emergency or for urgent requests for information.

If you agree to the foregoing terms, please indicate that by signing this form you accept the terms and conditions outlined herein.

ACCEPTED [ ]

_____ _____
Signature Printed Name Date

_____ _____
E-mail Address Date

DECLINED [ ]

_____ _____
Signature Date

Please send this authorization form to:
Debra S, Guthrie MD
185 Madison Ave, 2nd Floor
New York, NY 10016

Attn: _____