PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC

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Authorization To Communicate Via Email

This form when completed and signed by you authorizes me to exchange information with you via email. Most often this information includes clarification of your child's developmental history, or a confirmation of appointment dates/times. At times more personal information may be exchanged with you via email. However, should you request that test results or neuropsychological reports be released via email, this document will be password protected and the password will be emailed to you in a separate document.

I authorize Michelle Lurie, Psy.D.; ABPdN to exchange pertinent information to me via email. I understand that when using the internet to convey information, various limits to confidentiality may occur and this information may no longer be protected by the HIPAA Privacy Rule. I accept the risks involved in this exchange.

This authorization shall remain in effect until: / /

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken prior action in reliance on the authorization.

_____ _____

Signature of Patient /Guardian Date

Email Address:_____