RAHIM N. RAHEMTULLA, M.D.

Adult, Adolescent, and Child Psychiatry & Psychotherapy

Informed Consent for using email to communicate with Dr. Rahemtulla

Patient Name: _____/____/_____
last first middle DOB

Parent Name: _____
(if minor) last first middle

Requested Email(s): _____

I, the undersigned, certify that I am requesting communication with Dr. Rahemtulla via electronic mail (email). Risk exists that any protected health information contained in such email may be disclosed to, or intercepted by, unauthorized third parties. By signing this document, I acknowledge and understand this risk, and agree to communicate via email. I also acknowledge and understand that other, more secure methods of communication with Dr. Rahemtulla exist, including communication via telephone, fax, or non-electronic written communication. **Finally, I acknowledge and understand that Dr. Rahemtulla does not guarantee response within a certain period of time and that any urgent or emergent needs must be communicated via telephone or in person.**

_____

Signature of Patient (if 18 or older) Date

_____

Signature of Parent/Guardian Relation Date

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