Lukshmi Puttanniah, M.D.
Child, Adolescent, & Adult Psychiatry
155 N. Dean St.
Englewood, NJ 07631
Phone 201.308.3585 Fax 201.301.8895

Email Consent Form

This form is used to obtain your consent to communicate with you by email regarding your protected health information (PHI).

Dr. Puttanniah offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes.

Dr. Puttanniah will use reasonable means to protect the security and confidentiality of email information sent and received. However, Dr. Puttanniah cannot guarantee the security and confidentiality of email or SMS communication and will not be liable for inadvertent disclosure of confidential information.

<u>Patient's Acknowledgment and Agreement</u>

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Dr. Puttanniah and myself. I consent to the conditions outlined herein. Any questions I may have had were answered. I agree and consent that Dr. Puttanniah may communicate with me regarding my protected health information by e-mail.

Patient (or authorized representative) signature:____

Date: __________________________________

Patient Name: ____

Patient Address: ____

Patient/Authorized Representative E-mail Address: ______________________________________