Atlanta Psychological Services, LLC

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Check one: rev 10-13-18

___ J. Todd George, PsyD ___ Andrew Gothard, PsyD

___ Carolyn Johnson, PhD ___ Yoshitaro Oba, PhD

___ Jessenia Rodriguez, PsyD ___ Angela Stewart, PhD

CONSENT TO CORRESPOND ELECTRONICALLY

Client's name: _____

While the clinicians at Atlanta Psychological Services take reasonable precautions to protect your confidential information, I understand that e-mail and other sources of electronic communication are not completely secure methods of communication.

I understand that in most circumstances, electronic communication is not a way of communicating new information regarding care or of communicating emergency needs. I further understand that I must speak to my clinician directly regarding all important information pertaining to my (or my child's) treatment. Although my clinician will attempt to reply in a timely fashion, I further understand that if I (or my child) am experiencing an emergency situation and need to contact someone immediately to help me, then I will call any of the emergency numbers that are listed on the consent for treatment form.

I grant my clinician and/or staff of Atlanta Psychological Services permission to communicate with me via e-mail.

I acknowledge that if I use e-mail to initiate contact with my clinician at regarding my care (or my child's care), the clinician, and/or staff of Atlanta Psychological Services has my permission to correspond via that email address or other forms of electronic communications.

I acknowledge that I have the choice for my clinician or staff to include identifying information when e-mailing me.

_____ By checking this box, I allow my clinician or staff to send e-mails to me with identifying information without using encryption.

For adult clients:
Signature of Client: _____ Date: _____

For Minor Clients:
Signature of Parent or Legal Guardian: _____ Date: _____