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## ELECTRONIC COMMUNICATION CONSENT FORM

I \_\_\_\_\_ hereby give my consent and authorization for Melissa Rubin, ARNP (Melissa@[soundfamilypsychiatry.com](mailto:Melissa@soundfamilypsychiatry.com)) to use my phone number of \_\_\_\_\_ and/or my email address of \_\_\_\_\_ for communications as indicated by my signature on this form below.

### Initial below at each point you agree to:

\_\_\_\_\_ I understand that e-mail/text correspondence over the internet is non-encrypted and not secure.

\_\_\_\_\_ I understand that although it is unlikely, there is a possibility that information included in an email/text can be intercepted and read by other parties besides the person to whom it is addressed.

\_\_\_\_\_ I understand that I may revoke the use of my e-mail/text at any time by written notification.

\_\_\_\_\_ I understand that I may, at any time, choose to limit communications to appointment reminders only by written notification.

### Choose and sign only ONE option below:

I give my consent for my PHI (i.e. medication requests, address/phone updates, or any other correspondence containing personal health information including appointment reminders, etc..) to be communicated through email/text.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR

I give my consent for appointment reminders ONLY to be communicated through email/text.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian Name (Printed): \_\_\_\_\_