Patient Name:

DOB:

MR #:

Index to Auth – PHI

Date: _____

Mindfulness-Based Cognitive Therapy
Group for Depression and Anxiety

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

AGREEMENT FOR EMAIL COMMUNICATION WITH PROTECTED HEALTH INFORMATION – BEHAVIORAL HEALTH

As a patient in our clinics staff may communicate with you via email if you agree and sign this form. Video group links as well as handouts and references used in group will be sent via email.

Important points about receiving email from us:

1. Emails for group sessions come from a different email address than the one used for individual sessions. If you do not see an email about group, please check your spam/junk/promotions/deleted folders before contacting the clinic.
2. Our internal email (within the clinic) is HIPAA compliant and secure. However, **email external to UW Health is not encrypted**, and therefore not private. Unauthorized access by outsiders is possible. Do not reply to group emails from us, nor use email for discussion of sensitive issues or time-sensitive information. For example, mental health issues, substance use, etc. For assistance with any sensitive issues, call the clinic's main phone number as listed at www.uwhealth.org or send a message to your provider through MyChart.
3. If you use an email address provided by your employer, you should check with your employer about the security/ownership/privacy policy at your workplace. Your employer has the legal right to your email if they choose.
4. If you share an email account with family members, there is the possibility of revealing confidential information to others.

Patients are responsible for:

- Agreeing not to use email for medical emergencies or sending time-sensitive information to providers.
- Following up with their healthcare providers or staff if they have not received a response to an email within a reasonable time period.
- Informing UW Health registration of any changes to an email address.
- Informing their healthcare provider or staff in writing if they decide to discontinue using email communications.

Please sign below to agree to the use of email to communicate with you. Your signature signifies that you understand and agree to the above conditions on our use of email to communicate protected health care information. If you do not agree, we may not communicate in this manner, and you may not be able to participate in groups offered at UW Health.

Signature of Patient/Representative: _____ Date: _____/_____/_____ Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

- Patient is: ☐ Minor ☐ Incompetent/Incapacitated
- Legal Authority: ☐ Legal Guardian ☐ Parent of Minor
  ☐ Health Care Agent ☐ Other: _____

Reviewed by: _____ Date: _____/_____/_____ Time: _____