



CLIENT E-MAIL ACCEPTANCE FORM

I, _____, authorize Central Minnesota Mental Health Center (CMMHC) to utilize e-mail as a means of communication to me at the following e-mail address:

_____.

By signing this authorization, I understand the following information regarding e-mailing protected health information (ePHI):

Response from my Providers:

- I am aware that my provider may not respond in a prompt fashion due to a multitude of factors (e.g. meeting with other clients, business hours, vacation etc.). If I have not received a response, I agree to call or discuss with my provider at my next meeting.
- I agree to not use email communication for any crisis situation. I will utilize crisis or emergency services in these instances.

Privacy Issues

- I am aware of who else may intercept my e-mail (i.e. other family members, co-workers, etc.) and will be careful about leaving programs operational and/or documents visible/accessable when unattended.
- I have taken all precautions to eliminate others from accessing my e-mail, even during my absence. I will not hold Central Minnesota Mental Health Center (CMMHC) liable for others accessing my e-mail sent by CMMHC.
- It is my responsibility to protect the security of my passwords utilized to access my above stated e-mail address.
- I hold harmless CMMHC for information loss due to technical failures, such as system crashes, power outages, and overloads at the ISP level.
- The message (e-mail, including replies and confirmation receipts) will be included as a part of my medical records.
- CMMHC will avoid using e-mail for sensitive and urgent messages (ex. abnormal test results).
- Upon notification that an e-mail containing PHI was miss-directed, a notation to that effect will be written on a hard-copy of the e-mail and placed in the client's medical record. The recipient of the miss-directed e-mail will be asked to delete and destroy the e-mail that was sent in error.
- CMMHC will not forward client-identifiable information to a third party without my express written authorization (except for treatment, payment, and health-care operations).
- CMMHC will not use my e-mail address for marketing purposes and will not share my e-mail address with anyone, including family members.

Entity Authentication

- CMMHC will save my e-mail address in their e-mail system and utilize this stored e-mail address when e-mailing me.
- I will be asked to include my legal name and date of birth in the body of messages I send to CMMHC so that medical records are easily retrievable.



- I will utilize and obtain personal identification numbers when sending Credible e-mails to CMMHC so that they may be identified as a valid user CMMHC is authorized to reply to.

CMMHC Response to E-mail Requests

- CMMHC, will utilize the “Reply” option when responding to e-mail requests to ensure that the response goes to the individual who initiated the communication.
- If there is not a signed e-mail authorization, the individual will be contacted by CMMHC via telephone.

System Security

All e-mails containing protected health information (PHI) will be protected through access controls (restricting access categories that can be utilized are mandatory, discretionary, time-of-day, and classification) or encryption. Encryption key/passwords will be provided to clients via/ the agreed 128 bit form of encryption or provided e-mail accounts inside CMMHC’s system.

CMMHC’s E-mail system has an alarm for reporting and providing signals of abnormal conditions. Regularly scheduled security audits are performed to control and monitor accessing of information and event reporting of operational irregularities. Integrity controls are in place to ensure the validity of the information/content in the e-mail and of stored e-mails. A message authentication system is in place to ensure that the message that was sent is the message that is received, as well as an entity authentication system for identification of authorized and unauthorized users.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I may revoke this authorization at any time by providing my written revocation.

Name of Client/Previous Names

Birth Date

Signature of Client or Legal Representative

Date

Printed Name of Client’s Legal Representative

Relationship to the Client