Authorization to Transmit PHI via Email

I, _____, acknowledge and understand that Thomas Eye Group can not guarantee the safety of emailing medical records and/or protected health information (PHI). I understand that e-mail transmissions are not totally secure and could be monitored or reviewed by unauthorized individuals. I authorize the release of the medical records/PHI to be sent via email.

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Patient Name Date of birth

Please send a new email to crystalm@thomaseye.com with this authorization attached.

Thank you for your cooperation and assistance.