Alexandra Laifer, Ph.D.
Clinical Psychologist

*Helping You Achieve Personal Growth & Well-Being*

## AUTHORIZATION FOR ELECTRONIC COMMUNICATION

As a convenience to me, I hereby request that Alexandra Laifer, Ph.D. communicate with me regarding my treatment by Alexandra Laifer, Ph.D. via electronic communications (email or text message). I understand this means Alexandra Laifer, Ph.D. will transmit my protected health information such as information about my appointments, diagnosis, medications, progress, and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by email, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Alexandra Laifer, Ph.D. shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Alexandra Laifer, Ph.D. to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Alexandra Laifer, Ph.D. to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communication from Alexandra Laifer, Ph.D., I may revoke this authorization by providing written notice to Alexandra Laifer, Ph.D. at 2424 Vista Way, Suite 210, Oceanside, CA 92054 or fax at 760-721-1700.

I agree that Alexandra Laifer, Ph.D. may communicate with me electronically unless and until I revoke this authorization by submitting notice to Alexandra Laifer, Ph.D. in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

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| Signature of Patient | Print Name | Date |