

---

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) VIA EMAIL

In order for Dr. Russo to **correspond by email** and include potentially protected health information (PHI) to you, or your designee, please complete the following information.

**Email address** you would like the information sent to:

\_\_\_\_\_

I would like my information to be sent in a (check one):

- Secure format (encrypted)**
- Unsecure format**

I acknowledge that by electing to transmit and/or receive my health information in an unsecure manner, that the information will not be encrypted, and that it could be intercepted and viewed by a third party. The practice entity of La Jolla Cardiovascular Research Institute is not responsible for unauthorized access of your health information while in transmission to the email address you designate above.

**Printed Name:** \_\_\_\_\_

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

If signed by someone other than the patient, indicate:

Relationship to patient: \_\_\_\_\_

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

Witness: \_\_\_\_\_ Date: \_\_\_\_\_