Marni L. Jacob, Ph.D., LLC
Licensed Psychologist
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Consent for Email Communication

Marni L. Jacob, Ph.D., LLC offers patients the ability to communicate via electronic mail (e-mail) for non-urgent matters if, the arrangement is agreed to by both parties. E-mail communication should be limited and brief in nature.

Privacy and Security of E-mail:

Do not use e-mail to send or request sensitive information. Despite efforts to maintain privacy, Marni L. Jacob, Ph.D., LLC cannot and does not guarantee the privacy or security of any messages being sent over the internet. Dr. Jacob does not use email encryption. There is potential that e-mail sent over the internet can be intercepted and read by others. If this is of concern to you, you should not communicate with Dr. Jacob through e-mail. If you would like to share information with Dr. Jacob that you wish to be kept confidential, it is strongly recommended that you tell her in person or over the phone.

It is possible that e-mails can be misinterpreted. To minimize the potential of such errors, sensitive information should be discussed in person rather than via e-mail. Treatment recommendations will be discussed in session and not over e-mail.

Dr. Jacob does not maintain 24-hour access to email. In most cases, emails will be returned within 2 business days (48 hours; M-F). However, it is possible that Dr. Jacob may be unavailable by e-mail for an extended period of time. E-mail is not appropriate for use in an emergency. In an emergency, please call 911 or go to the nearest hospital.

E-mail communication between the patient and Dr. Jacob may become part of the patient's medical record. Emails may also be viewed by health care and insurance providers, and office support staff.

I have been informed of and understand the risks and procedures involved with using e-mail. I agree to the terms listed above and I hereby voluntarily consent to the use of e-mail as one form of communication with my provider.

Patient Name: ____ Date of Birth: _____________________

Parent/Guardian Name (if applicable): ____

Email Address: ____

Signature of Patient or Parent/Guardian: ________________________________ Date: _______________

Signature of Provider: ____ Date: _______________

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