Mark W. Wilson, MD
Executive Medical Director
Center for Wise Mind Living
Wise Mind Living Psychiatry
250 W54th Street, Suite 406
New York, New York 10019

Permission for Release of Information and Use of E-Mail Communication

I hereby give permission to Mark W. Wilson, MD

__ to *obtain* all pertinent information concerning client ______________________________

from: **Insurance, Medical Health Practitioners**______________________

and, ***if applicable***: **Therapist**______________________________________

Other Mental Health Practitioners__________________________

School; please clarify: verbal____, written____, no contact/no permission________

Other____

__ to *release* all pertinent information concerning client ______________________________

to: **Insurance, Medical Health Practitioners**______________________

and, ***if applicable***: **Therapist**______________________________________

Other Mental Health Practitioners__________________________

School; please clarify: verbal____, written____, no contact/no permission_______

Other____

__ to leave messages on client/caregiver's answering machine/voice mail and/or cell phone voice mail
__ to leave messages on client's work answering machine/voice mail
__ to communicate with me and my assistant via business level Gmail (which is encrypted only at the level of the server, but not at the level of the recipient, making it not HIPAA-compliant); by checking here and signing below, you acknowledge the following:

- **You understand that business-level Gmail is not fully encrypted, nor HIPAA-compliant, and you are opting in to using it to communicate with my assistant and me**
- **E-mail communication is vulnerable to privacy violations**
- **E-mail communication is part of the medical record**
- **E-mail communication is not a replacement for in-office assessment and treatment**
- **If e-mail communication is not clear or timely, contact Dr. Wilson via telephone or see me in person**
- **In the case of an emergency, contact Dr. Wilson by phone and/or call '911' or go to the nearest emergency room**
- **If you do not wish to use Gmail, you can opt out of regular email and can use instead the encrypted, password-protected, HIPAA-compliant MD Officemail, which you can discuss with Dr. Wilson, or you can simply use the phone to contact my office.**

This release of information **will expire at any time I choose to rescind** permission for release of information. I understand that in the event that permission for the release of information is not clear, Dr. Wilson will always ask for my clarification prior to release of information.

Also,

__ I have received, read, and reviewed Dr. Wilson's "Notice of Policies, Consent for Treatment, and Notice of Privacy/Confidentiality Rights", and I understand and agree with the policies described in that notice.

SIGNATURE OF CLIENT (if 18 yo+)**:X**__________________________

Name of **CLIENT** (if 18 yo+)**:**______________________________

Witness ***MWilson, MD:X***________________________________

SIGNATURE OF CAREGIVER (if < 18 yo):X______________________

Name of **CAREGIVER** (if < 18 yo):____________________________

Date: / /