

Integrative Medical Associates

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650-474-2130 (option #4)

License #G47925 DEA #AS6638994

**Authorization and Consent for Unencrypted Transmissions**

I authorize Integrative Medical Associates to transmit patient information relating to my treatment, health, or payments by email or other electronic means, without encryption or special security precautions, to me or other party designated by me herein.

The patient information that may be emailed may include my health history, diagnosis, treatment, and payment records, labs, supplements/Rx’s and other applicable records.

I understand and accept that there are risks that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be disclosed and no longer protected by privacy law. –I understand that Integrative Medical Associates does not email personal information as Social Security numbers, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse or positive HIV status unless the patient insists.

 I can discontinue this authorization by supplying in writing a request to do so.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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