THOMAS L. HOROWITZ, D.O.

BOARD CERTIFIED

FAMILY MEDICINE

1300 North Vermont Avenue
LOS ANGELES, CA 90027

TELEPHONE (323) 666-5550
FAX (323) 666-5552
Thomashorowitz.com

Online Communication Authorization

Patient Name ____

Confidential Email Address ____

I authorize Dr. Horowitz and his staff to communicate with me by standard email, using the email address above, for the following activities **initialed** by me:

- (   ) Test Orders and Results
- (   ) Prescription Refills
- (   ) Appointment Requests, Reminders and Referrals
- (   ) Questions, Education and General Care Management
- (   ) Other/Miscellaneous Correspondence
- (   ) Payment (Debit/credit card transactions are Payment Council Industry compliant with end-to-end encryption by Heartland Connect)

Credit Card No. ______________________________

Cardholder Name ______________________________

Billing Address ______________________________

Expiration ______________________________

CVC Security Code ______________________________

I understand that email service is not secure and is not for use by patients or for healthcare purposes in general. I understand that online communication cannot be used for emergencies, time sensitive matters or highly sensitive medical information. I will call the office if there is not timely response to an email. I understand that alternative methods of communication (i.e. telephone, in person, mail) are still available to me. I understand that I am responsible for taking steps to protect myself from unauthorized use of online communication. The doctor is not responsible for breaches of confidentiality caused by an independent third party or me. I understand that Dr. Horowitz's office will use my email address for communication only with me and will not release my email address to anyone. Dr. Horowitz's Notice of Privacy Practices has been presented to me. I acknowledge that the Notice is available in the reception area, on the practice website, and by email or paper copy upon request.

I hereby authorize Dr. Horowitz's office to keep my debit/credit card account information on file for payment and to initiate debit or charge entries on this account as amounts are owed and authorized by me. I acknowledge that the debit/credit card transactions to my account must comply with the provisions of US law.

I certify that I have read and fully understand this authorization form. This authorization shall remain in effect until Dr. Horowitz's office receives written notification from me of its termination.

______________________________________ Date/Time ______________________

(Signature of Patient)