

Haile Psychiatry and Psychotherapy Group
Susan Tran, MD

E-Mail Correspondence Consent Form

I, _____, have read the **E-Mail** and agree to indemnify and hold harmless Dr. Tran, her medical practice, Haile Psychiatry and Psychotherapy Group, information providers and suppliers and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider or the use of Provider's web-site, any arrangements you make based on information obtained at the Site, any products or services obtained through the Site, and any breach by me of these restrictions and conditions. The Provider does not warrant that the functions contained in any materials provided will be uninterrupted or error-free, that defects will be corrected, or that the Provider's website or server that makes such site available is free of viruses or other harmful components.

Dr. Tran shall have the right to immediately terminate the e-mail relationship with you if she determines, in her sole discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines, in her sole discretion, to be unacceptable. The e-mail relationship between the Dr. Tran and the patient will terminate in the event the Provider, in his/her sole discretion, no longer wishes to utilize the e-mail to communicate with all of her patients.

I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Dr. Tran and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Dr. Tran or her representative may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient or Parent/Guardian's signature

Date

Witness signature

Date

E-mail address of Patient or Parent/Guardian of Patient