DR Story Neurology, PLLC
280 Dobbs Ferry Road, Suite 206
White Plains, NY 10607
P: (914) 888-6662
F: (888) 975-0935
drs@drsneurology.com

Electronic Correspondence Consent Form (10-2-15)

I hereby authorize Dr. Daryl Story to utilize electronic communications (email / text) to communicate clinical information to me. I acknowledge and understand that such communication may contain personal and private medical information of mine including, but not limited to, my name, address, social security number, date of birth, race and ethnicity demographics, types and dates of health care services received, name and address of the provider administering each health care service, insurance coverage information and/or test results (the "Medical Records").

I acknowledge and understand that, although Dr. Story may engage in certain practices in order to protect the privacy of the contents of any electronic communications sent to me and will take all reasonable measures to protect my privacy, the email or text messages sent to me are not encrypted and travel over the Internet and, as a result, there is a risk that the communication will be intercepted and read by third parties to whom the email is not directed. In authorizing Dr. Story to send me email or text messages, I assume the foregoing risk.

I acknowledge that I am responsible for the security of electronic communications sent from or stored on my computer or device, including, but not limited to, protecting access to any messages stored on my computer or device, implementing security measures when delivering electronic communications from my computer or device and implementing virus protection on my computer or device.

I understand that email, phone voice mail, text, and fax are not appropriate means for conveying information relating to urgent or emergency medical matters. In the event of a medical emergency I should contact 911 or go to the nearest Emergency Department.

I understand that email, phone, text and fax communication are not a substitute for medical care and evaluation. I must arrange for an office appointment to assure appropriate care regularly.

I acknowledge that Dr. Story will only use my contact information for communication with me and will not sell, transfer or otherwise disclose my e-mail address, phone number, or any of my other personal information to any third parties.

I understand that I am responsible for notifying Dr. Story if I chose to discontinue email communication or if my contact information has changed.

I have read and fully understand the meaning of this authorization.

Name:_____

Signature:_____ Date:_____