

Mitchell A. Kline, M.D., P.C.
700 Park Avenue
New York, NY 10021

Patient Request for Email Communications

Patient Name: JEFFREY EPSTEIN Date of Birth: JAN 20, 1953
Phone Number: 212-750-9895 Email Address: jeevacation@gmail.com

Communications over the Internet and/or using the email system are not encrypted and may not be secure. There is no assurance of confidentiality when communicated via email. To request that this provider communicate with you via email you must complete this form.

Please be advised that:

1. This request applies only to the healthcare provider that you indicate below. If you would like to request to communicate via email with another health care provider or program, you must complete a separate request for that office.
2. DR. MITCHELL A. KLINE will not communicate health information that is specially protected under state and federal law (e.g., HIV/Aids, substance abuse, mental health information) via email.
3. Your request will not be effective until you receive and respond appropriately to a test email message.

Please select the question you want to use (by checking one of the boxes below) for your test email and provide your answer.

- My mother's maiden name: _____
- My middle name: _____
- The street number of my residence: _____

I understand and agree to the following:

- I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form, and I have read and understand it.
- I understand and acknowledge that communications over the Internet and/or using the email system are not encrypted and may not be secure: that there is no assurance of confidentiality of information when communicated this way.
- I understand that all email communications in which I engage may be forwarded to other providers for purposes of providing treatment to me.
- I agree to hold DR. MITCHELL A. KLINE and individuals associated with him harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

Signature of patient or personal representative

JAN. 11, 2019
Date

If personal representative, authority on behalf of patient

Name of Physician or Program

September 23, 2013