

Consent for Electronic Communication

Client Name: _____ DOB: _____

This form, when completed and signed by you, authorizes your therapist/APPS staff to release and/or exchange protected information from your clinical record using electronic mail (e-mail) or other forms of electronic communication.

ASSUMPTIONS

- E-mail/text messages can be immediately broadcast worldwide and be received by many intended and unintended recipients. E-mail and other forms of electronic communication are not "secure" means of communication.
- Recipients can forward e-mail or text messages to other recipients without the original sender's permission or knowledge.
- Users can easily misaddress an e-mail message or text message.
- E-mail or text messages may be altered and is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail or text messages may exist even after the sender or the recipient has deleted his/her copy.
- E-mail or text messages containing information pertaining to a patient's diagnosis and/or treatment constitutes a part of the patient's medical record. All e-mail and text messages may be discoverable in litigation regardless of whether it is in a patient's medical record.
- Messages transmitted via e-mail or text messages may not be picked up in a timely fashion. To avoid unnecessary delays in the transmission of important information, do not use e-mail or text messages to send urgent messages.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and may no longer be protected by the HIPAA privacy rule. You have the right to revoke this authorization, in writing, at any time by sending such written notification to the APPS business address. Your revocation will not be effective to the extent that APPS staff have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.

_____ I(we) understand the assumptions stated above and understand that electronic communication (text, email, cell phone) is not a secure means of communication. I am aware that the provider may decline to communicate via electronic communication based upon the nature of the medical information. I give permission for APPS to use electronic communication as a means of communication regarding my care. I understand that I may withdraw this authorization at any time by notifying APPS administrative staff or my therapist in writing.

Please initial on line and circle choice:

_____ Email communication is: **Permitted** **Not Permitted**
 _____ Text communication is: **Permitted** **Not Permitted**

This provider does not use any communication made through social media sites, such as Facebook, MySpace, Instant Messaging, LinkedIn, etc.

By signing below I understand and agree to the above stated policy regarding electronic communication.

Signature: _____ Date _____