CONSENT FORM FOR RELEASE OF CONFIDENTIAL INFORMATION AUTHORIZING COMMUNICATION BY EMAIL

I, ______________________________whose birth date is ________________authorize

my clinician, ____________________________________ to communicate with me via email

at this email address: ____

I understand that sensitive information including diagnosis, information about specific problems, treatment plans, or medical records will not be sent via text or email. I have received information about risks and benefits of electronic communications, and I am aware of the importance of setting a security lock on my phone and/or email account.

I am aware that:

- my email may not be viewed for 1-2 business days.
- there may be a charge for review of records or information sent to my clinician via email.
- in-depth discussion of clinical issues should be reserved for scheduled sessions only.
- email that I send or receive may be viewed by others.
- I should call 911 in an emergency, and never use email to ask for help in a crisis.
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I authorize these types of messages:

◊ information about appointments (reminders, updates, changes, cancellations, etc.)
◊ reminders about completing recommended activities
◊ email attachments such as information pamphlets, worksheets, self-help guides, etc.
◊ information about trainings or workshops that may be of interest to me
◊ other:____

for the purpose of electronic communication with my clinician about the above issues.

I understand that my records are protected under Federal Confidentiality Regulation (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may (in writing) revoke this consent at any time except to the extent that disclosure was made prior to the time I revoked it. I further understand that disclosure includes the right of the recipient to inspect and receive copies of the information to be disclosed.

This consent remains in effect as long as I am a patient of this clinician, unless I revoke it. If I refuse to consent to this authorization, I will not receive electronic communications from my clinician.

____ ____________________
Signature of Client or Participant Date

____ ____________________
Signature of Parent/Guardian/Authorized Representative Date

____ ____________________
Signature of Witness Date