



CONSENT FOR E-MAIL COMMUNICATION OF PRIVATE HEALTH INFORMATION

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

Name of Client: _____ Date of Birth: _____

_____ Date of Birth: _____

Address: _____

Client e-mail address: _____

Other approved recipients: _____

(note: A current Consent for the Release of PHI form for each approved recipient must be on file in addition to this form.)

Assumptions

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

You understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and may no longer 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 FACTS business address. However, your revocation will not be effective to the extent that FACTS 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 e-mail is not a secure means of communication. I am aware that the provider may decline to communicate via e-mail based upon the nature of the medical information. I give permission for FACTS to use electronic mail as a means of communication regarding my care. I understand that I may rescind this authorization at any time by notifying FACTS administrative staff or my therapist in writing.

_____ *This consent will expire within one year from the date of signature or when the purposes for which it was granted have been accomplished, whichever occurs first.*

_____ *This consent will expire 30 days following the end of services through FACTS.*

Client

Date

Client

Date

Client

Date

Witness / Credentials

Date