Behavioral Psychology Associates

AUTHORIZATION FOR ELECTRONIC COMMUNCIATION

It may become useful during the course of treatment to communicate by email, text message or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with your clinician at Behavioral Psychology Associates there is a chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

· People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.

· Your employer, if you use your work email to communicate with your clinician at BPA.

· Third parties on the internet such as sever administrators and others who monitor Internet traffic.

Printed Patient Name:_____ Date of birth:_____

Address: _____ Telephone Number:_____

City:_____ State:_____ Zip Code:_____

I hereby authorize Behavioral Psychology Associates, P.C. and/or _____to transmit the following protected health information related to my health record and health care treatment:

☐ Information related to the scheduling of meetings or other appointments

☐ Information related to billing and payment

☐ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment

☐ My health record, in part or in whole, or summaries of material from my health record

☐ Other information. Describe:_____

BY THE FOLLOWING MEDIA:

☐ Email.

☐ Text messaging (only for administrative purposes, for example scheduling, or canceling an appointment).

TERMINATION

This authorization will terminate on the following date (not to exceed one year) :_____.

I have been informed of the risks of transmitting my protected health information by unsecure means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____	_____	_____	_____
Signature of patient	Date	Signature of Parent or Legal Representative	Date

Patients ages 12 to 17 years of age must sign in addition to the parent or legal representative. If signed by a legal representative, indicate the relationship or authority to act for patient.