Nexus-FACTS
FAMILY HEALING

Family, Adolescents, and Children Therapy Services

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Consent for Electronic Communication

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

Name of Client: _____ DOB: _____

Name of Client: _____ DOB: _____

Name of Client: _____ DOB: _____

Client Email Address: _____

Cell phone number: _____

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 and other forms of electronic communication are not "secure" means of communication.
- Recipients can forward e-mail messages 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 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 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 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.

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 Nexus-FACTS business address. Your revocation will not be effective to the extent that Nexus-FACTS staffhave 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.

EMAIL COMMUNICATION 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 Nexus-FACTS to use electronic mail as a means of communication regarding my care. I understand that I may withdraw this authorization at any time by notifying Nexus-FACTS administrative staff or my therapist in writing.

TEXT MESSAGING I (we) understand the assumptions stated above and understand that text messaging is not a secure means of communication. I am aware that the provider may decline to communicate via text messaging based upon the nature of the medical information. I give permission for Nexus- FACTS to use text messaging as a means of communication both between myself and r other service providers regarding my care. I understand that I may withdraw this authorization at any time by notifying Nexus-FACTS administrative staff or my therapist in writing.

OTHER ELECTRONIC COMMUNICATION I (we) understand the assumptions stated above and understand that electronic communication is not a secure means of communication. This includes any communication made through social media sites, such as Facebook, MySpace, Instant Messaging, LinkedIn, etc. The provider will not participate in or accept requests to communicate through these types of services, either with clients or friends/family members of clients. I am aware that the provider may decline to communicate in this manner based upon the nature of the medical information. I give permission for Nexus FACTS to use other forms of electronic communication regarding my care. I understand that I may withdraw this authorization at any time by notifying Nexus-FACTS administrative staff or my therapist in writing.

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

Parent/Guardian Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____