

Authorization for Electronic Communication

This form does not apply to verbal telephone or fax communication, or appointment reminders sent via verbal phone call or text.

Client Name (please print): _____ Date of Birth: _____

Client Address: _____ City/State/Zip: _____

Client Account Number: _____

Please mark one box:

- I request and give permission** for Porter-Starke Services and/or Marram Health Center to communicate with me electronically via text, email or other electronic means as is necessary to provide my treatment and other business needs related to the services I receive. I understand these communication methods are using **unsecure text messaging and/or unsecure email**. I understand that by providing my information and requesting electronic communication, that I am accepting the risk for a possible unauthorized disclosure. I understand if I share my phone account or email account with another person outside of Porter-Starke/Marram, that person would be able to view my private health information. If my phone # or email address below changes, I am responsible to update that information and submit an updated Authorization for Electronic Communication form. If my information is disclosed without my authorization, or my device(s) is/are lost or stolen, I will not hold Porter-Starke Services or Marram Health Center responsible for any disclosure that may occur.

Text/Phone Number: (_____) _____ **Fax Number:** (_____) _____

Email: _____

By signing below, I attest that the text/phone number, fax number or email address provided above solely belongs to me, or I have given permission to share with another person. I understand that secure communication methods are available to me but I am declining to use the secure communication method, and am choosing to use unsecure electronic communication.

I fully understand that my medical record contains confidential physical, mental health, substance abuse, and/or HIV/AIDS information compiled in the course of my treatment. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, as required by law. I understand that records not protected by Federal confidentiality rules (42CFR Part 2) may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I cannot be required to sign this authorization as a condition for having treatment provided or obtaining payment for the same.

Date, event or condition this authorization expires: _____. If no date, event or condition is specified, this authorization expires 60 days after services have been terminated or when all financial responsibilities have been satisfied. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written or oral revocation request to the Health Information Department.

- I decline** for Porter-Starke Services and/or Marram Health Center to communicate with me electronically via text, email or other electronic means as is necessary to provide my treatment and other business needs related to the services I receive.

Client/Guardian Signature: _____ Date: _____

Relationship to Client: _____