

Authorization for Electronic Communication

As a convenience to me, I hereby request that Trauma Informed Therapies, PLLC communicate with me regarding my treatment by Trauma Informed Therapies via electronic communications (internet, e-mail or text message). I understand that this means Trauma Informed Therapies and/or my treating providers will transmit my protected health information, including video conferencing (encrypted), information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization (except as noted above) may not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Trauma Informed Therapies shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Trauma Informed Therapies to me.

After being provided this notice of the security risks inherent in use of electronic communications, I hereby expressly authorize Trauma Informed Therapies to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Trauma Informed Therapies, I may revoke this authorization by providing written notice to Trauma Informed Therapies at 222 W. Mission, Suite 122, Spokane WA 99201 or fax at 509-315-8945.

I agree that Trauma Informed Therapies may communicate with me electronically unless and until I revoke this authorization by submitting notice to Trauma Informed Therapies in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

Patient/Client Name

Signature of Patient/Client

Date