Patient E-mail or Text Message Authorization Form

I, _____, authorize Dynamic Mental Health of New England, PLLC (DMHNE) to contact me at the following email address or phone number:

_____

Risks:

• I understand that if DMHNE contacts me by e-mail or text, the most likely risk to my personal health information is that information intended for me could be sent to the wrong person by mistake.

• I also understand that there is a risk that my e-mail account could be hacked, and that email sent to me could be monitored, intercepted, read, and/or altered before it reaches my e-mail in-box.

• I have been informed that internet e-mail is sent via relay servers, and that anyone with access to a relay server has the ability to read an e-mail saved on the relay server. I have also been informed some relay servers store copies of the messages even after they have been sent to the final recipient.

Acknowledgement and Agreement:

1. I have read and understand the risks associated with e-mail communications, and I understand there may be additional risks not described here.

2. I understand that DMHNE cannot control who reads my e-mail or text messages, while in route or when delivered to my e-mail account or phone.

3. I hold DMHNE harmless from any liability for sending my protected health information by e-mail or text message, or for any unintentional misdirection of e-mail or text messages to someone other than me. I have read and understand the risks associated with e-mail and text communications.

By signing this authorization, I confirm that it accurately reflects my wish to receive health information by e-mail or text message, and I will not hold DMHNE liable for any unintentional disclosure of my health information in an e-mail or text message. I understand that I may revoke this authorization in writing at any time.

Signature of Patient:

_____ Date: _____

Name of Guardian/Representative of the Patient (if applicable):

_____

Signature of Guardian/Representative of the Patient (if applicable):

_____ Date: _____

If signing as a guardian or legal representative of the patient, please describe your authority to act for this individual (parent with legal decision-making authority, power of attorney, healthcare surrogate, etc.):

_____