Psychology Associates of Grand Rapids

CLIENT AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

Client Name:__________________________ Birth Date: ____________

Purpose of Request: I authorize the Practice and my Provider, ________________________, to disclose Protected Health Information (as described below) directly to me at the e-mail address and/or text number I have indicated. I understand that it is my responsibility to notify the Practice and my Provider of any changes in my e-mail address and that any disclosure made to the e-mail address, indicated by me, is subject to the redisclosure statement within this authorization.
E-Mail Address: ________________________________ **Text Phone Number: ______________________**
I authorize the Practice and my Provider to disclose the following Protected Health Information about me to the e-mail address I have indicated (please provide a written description of the information to be disclosed):

☐ Appt Scheduling Only ☐ Clinical Updates ☐ Other:____________________

Purpose of Disclosure: I am authorizing the disclosure of my Protected Health Information to the specified e-mail address as a means of enhancing communication with my healthcare Provider and the Practice.

Expirations or Termination of Authorization: This authorization will expire one year from the date it was initiated, unless I specify an earlier termination. I understand that I must submit a new authorization after the expiration date to continue the authorization. I also understand that I have the right to terminate this authorization at any time. Desired termination date: _____________.

Right to Revoke or Terminate: As stated in the Practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization by submitting a written request to the Practice's Privacy Manager. This may be presented in person, or by mailing a request to the Practice, Attn: Privacy Manager.

Re-Disclosure: I understand that the Practice has no control regarding persons who may have access to the e-mail address I have listed to receive my Protected Health Information. Therefore, I understand that my Protected Health Information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this Practice.

Use of Electronic Communication: I understand that electronic communication is not intended to be used for therapy. I also understand that it is not to be used for clinical emergencies or urgencies. I acknowledge that there may be a fee associated with the exchange of electronic communications, and the clinical review of and response to that communication. I understand that any fee charged will not be billed to my insurance carrier and I hereby agree to pay any fee assessed. Fees will be charged at the clinical hourly rate unless otherwise indentified as _____________________________.

___________________________________ ___________________________________

Client Signature Witness Signature

Date: ______________________________ Client Copy Provided: ____ Yes ____ No