AUTHORIZATION FOR ELECTRONIC COMMUNICATION

LITTLE BIRD PSYCHOTHERAPY, P.S., INC

By signing this form I authorize Little Bird Psychotherapy (LBP) to communicate with me electronically via telephone, email, texting, faxing, the LBP website, internet patient portal, designated insurance &/or EAP websites, appointment scheduling sites and claims filing sites. These communications will be used for scheduling and for collecting or sending pertinent clinical, insurance information and claims, billing &/or collections information as is necessary to provide your treatment and or to correspond.

- I understand that communications via the means as described above, are not always secure. Although it is unlikely, there is a possibility that information you send to me, or that I send to you, may be intercepted and read by other parties besides the person to whom it is addressed.
- My signature on this disclosure indicates that I am giving my permission to engage in the electronic and internet communication described above. I hereby release Little Bird Psychotherapy, from any and all liability that may arise from the release of electronic information.
- I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization I must do so in writing and address it to Little Bird Psychotherapy. I understand that if I revoke this authorization, it will not apply to any information previously released as a result of this authorization. I understand that I may refuse to sign this authorization. I also understand that Little Bird Psychotherapy cannot deny or refuse to provide treatment or billing services if I refuse to sign this authorization. I understand that once the information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

Emailing and text messaging (and other online "activities") have become a common and convenient way to communicate with virtually any service provider with whom you work. Electronic communication, via email and text, between you and your therapist may not be secure. By signing below, you are acknowledging that you realize that email and text communication does not provide a completely secure means of communication. While I will make reasonable efforts to protect your confidentiality, there is some risk that any protected health information contained in email or text may be disclosed to or intercepted by unauthorized third parties. Your treatment will not depend on you giving consent and you also have the right to terminate this agreement at any time. However, if you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, it is necessary to provide consent.

Please be advised of the following conditions:

- Emailing and texting is not appropriate for urgent or emergency situations. I cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
- Email and texts should be concise. The client should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- Client's do not have a right to privacy within their employer's email systems, and therefore it should not be used to send or receive confidential medical information.
- All electronic communication regarding confidential medical information will be also printed and maintained in the client's file.
- LBP will not forward client's identifiable emails and/or texts without the client's written consent, except as authorized by law.
- Clients should not use email or texts for communication of sensitive personal or medical information, nor should it be used for casual communication.
- LBP is not liable for any breaches of confidentiality caused by the client or any third party.

Use of more secure communications, such as phone or fax, are always an alternative that are available to you if you elect to not give consent to above described forms of communication.

I have read the above document and understand the limits of confidentiality regarding electronic communications.

This consent is valid for the entire course of treatment and may be withdrawn by the client, in writing, at any time.

Client Signature	Client Name (printed):	Date
Parent/Guardian Signature*	Parent/Guardian Name (printed)*	Date