MindfulGuidance - Authorization Form for Encrypted or Unencrypted Email/Text/SMS Messages

Client's Full Name | **Client's Email Address**

Address | **Client's Date of Birth**

City, State Zip Code | **Client's Telephone Number** (mobile)

I hereby authorize use or disclosure of protected health information about me as described below.

1. I, _____, agree to send and/or receive email, text and SMS messaging as follows:

   1) ____ I will receive/use only encrypted forms of email and text/SMS communications 2) ____ I prefer to use unencrypted forms of email/text/SMS messages

   I attest that I have been fully informed of and understand the risks of sending and receiving encrypted and unencrypted email and text/SMS messages. **Yes No (circle one)**

2. The following person (or class of persons) may receive and send protected health information about me:

   1) Lisa Love/MindfulGuidance Coaching & Counseling, 2) Yellow Schedule, 3)Ivy Pay, and/or 4)Availity (circle which apply)
   His/her/its Name

   1) 183 Park Row Brunswick, Maine 04011 2) YellowSchedule.com 3) TalktoIvy.com 4) Availity.com
   Address

3. The specific information that may be disclosed is:

   1) Appointment reminders from Lisa or Yellow Schedule, 2) Information about my treatment plan, 3) Verification of payment through Ivy Pay, 4) Therapeutic communications between sessions, 5) Requests for more information or clarification about topics we covered in session, 6) Notice of late cancellation, the need to reschedule or notification of running late for scheduled appointment, 7) links to helpful articles or websites related to my treatment.

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION * _____
   NO, DO NOT DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying **Lisa Love/MindfulGuidance** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for ease of communication, clarification, and/or support between sessions.
7. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual* (The person about whom the information relates) | **Date of Individual's Signature** | **Date of Birth**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate | **Date of Guardian's/Personal Representative's Signature** | **Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signature.

Official Use Only

Received | **Processed By** | **Log #**