Grounded Roots Counseling Services

**Consent for Communication Form**

*There are several ways in which we may need to contact one another. This form explains those instances and to receive permission from you on the best way to reach you.*

**Correspondence**

* It is okay to leave a message at the following:

Home Address □ YES □ NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(address to receive mail)

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ YES □ NO

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ YES □ NO

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ YES □ NO

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give consent for you to contact my emergency contact in the event of an emergency: □ YES □ NO

( □ I do not wish to list an emergency contact)

**Electronic Communication**

**Benefits.** E-mail can be a convenient way to communicate about appointments, billing, or providing brief information between appointments. It is also a beneficial way for your therapist to communicate with other professionals (e.g. school, caseworker, probation, etc). Our electronic health record can automatically send appointment reminders sent through e-mail or text, which many clients find helpful.

Each therapist has an e-mail account that can send both encrypted and unencrypted e-mails. Our Client Portal also offers secure messaging (this allows you to exchange messages about appointments on a secure platform).

**Risks.** It is important to be aware of the limits of confidentiality before choosing to use electronic communication with your therapist. Below explains the limitations.

***Unencrypted***text and e-mail messages can be compromised in two ways:

1. When the message is sent unencrypted, the message may be read by third parties who monitor internet traffic, such as server administrators. If a work e-mail is used for communication, employers may have access to any messages that are sent or received.
2. If someone else has access to your phone, computer, or other devices, they may be able to read your e-mails or texts.

If you choose to send and receive messages through the Client Portal, you will receive an unencrypted e-mail from your therapist each time there is a message waiting for you. For 15 minutes from the time this e-mail is opened, it can be used to access the Client Portal without entering your username and password. Thus, anyone who has access to your e-mail could access information in the Client Portal (such as shared documents and upcoming appointments times) during that time.

***Encrypted*** messages can only be accessed if the recipient enters a unique password. The requirement for a separate password is less convenient, but encryption adds a level of increased security and makes it very difficult for anyone besides the intended recipient to access the e-mail.

**Limits to Electronic Communication.** Electronic communication is to be utilized for scheduling or rescheduling an appointment or sharing of brief information between appointments. It is imperative it is not used for sensitive information that is best addressed in a counseling session. It should never be used to communicate in the case of an emergency. While we try to return messages in a timely manner, we are in appointments throughout the day and may not check messages outside of regular business hours. Please do not expect an immediate response to electronic communication. *All electronic communication will become part of your clinical record.*

**Authorization.**

**I have reviewed the Consent for Communication Form and understand the risks, including but not limited to my confidentiality in treatment, of transmitting my Protected Health Information electronically. I understand that I am not required to sign this agreement in order to receive treatment, and I may terminate this authorization at any time with written notice. I understand all electronic communication will become part of my record. I agree to not send any sensitive information or communicate times of crisis through electronic communication.**

I authorize my therapist to communicate my Protected Health Information related to my clinical records and treatment in the following ways through electronic communication:

*Check all that apply. Please indicate whether you prefer e-mails to be encrypted or unencrypted.*

□ Automated appointment reminders sent via SMS text message

Preferred Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Automated appointment reminders sent via unencrypted e-mail

□ E-mails about scheduling and appointment times □ Encrypted □ Unencrypted

□ E-mails regarding billing and payment, including invoices □ Encrypted □ Unencrypted

□ I would like to use the Client Portal to exchange messages with my therapist □ Encrypted □ Unencrypted

□ I give consent for my therapist to e-mail my (or my child’s) teacher, caseworker, or other person for whom I have provided consent. I understand my therapist will not include any identifying information in any unencrypted e-mails. Any communication with third parties that specifically identifies myself (or my child) will be encrypted.

Preferred E-mail Address(es): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I do not want to use electronic communication

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of parent or guardian (if legally required) Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of parent or guardian (if legally required) Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist Date**