



## Authorization for Electronic Communication

As a convenience to me, I authorize Crossroads Counseling & Psychotherapy, LLC to communicate with me regarding my treatment via electronic communications (email or text message) and to transmit my protected health information electronically as described below. I understand there are risks inherent in the electronic transmission of information by email or text message:

- Such communication does not provide a completely secure means of communication.
- Any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted.
- Electronic transmission of information cannot be guaranteed to be secure or error-free.
- Data may be vulnerable to access by unauthorized third parties.

As such, Crossroads Counseling & Psychotherapy, LLC shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Crossroads Counseling & Psychotherapy, LLC to me.

Text Communication:       Yes       No

Authorized phone number(s): \_\_\_\_\_

Email Communication:       Yes       No

Authorized email address(es): \_\_\_\_\_

Other:       Yes       No

Authorized service(s): \_\_\_\_\_

Your treatment does not depend on consent. You have the right to terminate or amend this agreement at any time. The use of more secure communication methods, such as messaging through your TherapyNotes Patient Portal or Spruce are alternatives always available if you elect to not give consent to any of the forms of communication listed above.

I understand that Crossroads Counseling & Psychotherapy, LLC may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to Crossroads Counseling & Psychotherapy, LLC in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

## Authorization for Electronic Communication

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Patient Name

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Signature of Patient

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Date