THRIVEWELL MENTAL TELEHEALTH, PLLC.

82 Wendell Avenue STE 100
Pittsfield, MA 01201

CONSENT TO COMMUNICATE BY TEXT/EMAIL

Patient Name *

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I understand that it may be necessary at times to communicate outside of our scheduled sessions, please choose methods of contact that you authorize your Provider to use

Phone Number

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Text Number

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Email

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I understand that the transmission of protected health information (PHI) via unsecured and unencrypted email or text messaging has a number of risks to be considered before making a final decision regarding its use. These include but are not limited to: • The email and phone systems used by you, the client, and the Provider may not be equipped with encryption or firewall devices, etc. Therefore, there is no way to guarantee confidentiality at either end of the communication. • Text and email message can be circulated, forwarded, or stored in electronic files. • Text and email messages can be immediately broadcast worldwide and received by many intended and unintended recipients. • Senders can easily misaddress a text or email message. • Text messages are easier to falsify than handwritten or signed documents. • Backup copies may exist even after sender and/or recipient has deleted their copies. • Text and unsecured email messages can be intercepted, altered, forwarded, or used without detection or authorization. • Email and text messages can be used as evidence in court and are subject to subpoena in the event of court cases. • Text and email messages can be lost in transmission. • The transmission or receipt of text and email on a mobile device, such as a smartphone or tablet, poses an additional risk because such mobile devices are frequently lost or stolen. You are encouraged to employ password protection and auto-lock on any mobile devices on which you send or receive information from the Provider. The Provider has taken reasonable safeguards to protect the privacy and security of any transmitted information. However, because of the risks outlined above, cannot guarantee the security and confidentiality of email and text message communication and will not be liable for improper disclosure that is not caused by my intentional misconduct. The provider recommends that when electronically transmitting information to his practice, information be kept to the minimum necessary, i.e., appointment times and dates only. In consenting to email and/or text communication, you understand that you are responsible for protecting your electronic device by password or other means of access. Thrivewell Mental Telehealth, PLLC is not liable for breaches of confidentiality caused by a client or other third party. I acknowledge that I have read and fully understand this consent form. By signing this consent form, I expressly authorize Thrivewell Mental Telehealth, PLLC to communicate with me via email and/or text message. I understand the risks as outlined above and waive all claims that may arise against the provider resulting from the use or misuse of unsecured and unencrypted email or text messaging. I understand I have the right to delineate in writing any information that I do not want sent via email or text message. I also understand this Waiver is voluntary and that I may revoke my consent, in whole or in part, at any time by providing written notice to the Provider. Lastly, by signing this document, I acknowledge that the phone number and e-mail listed at the top of this form are approved and authorized for the transmission of unsecured and unencrypted text messages, e-mails and voicemails.

Checkbox *

☐ By checking this box you agree to receive recurring messages from Thrivewell Mental Telehealth, Reply STOP to Opt out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages. No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All OPT-IN requests include text messaging originator opt-in data and consent; this information will not be shared with third parties.

Please sign your name below *

Signature ____________________ Date ____________

☐ I am the parent/guardian of this patient