Amy Luzar, LISW-S
Authorization for Electronic Communication

As a convenience to me, I hereby request that Amy Luzar, LISW-S communicate with me regarding my treatment via electronic communications (e-mail or text message). I understand that this means Amy Luzar, LISW-S will transmit via electronic communication my protected health information (PHI) which will include information about my appointments, diagnosis codes and CPT (type of service) codes that are minimally necessary for the purpose of creating invoices and receipts.

Amy Luzar, LISW-S uses the email address amy@amyluzar.com which is HIPAA compliant; however, for scheduling and general emails, it is not encrypted. Text messaging is neither HIPAA compliant nor encrypted. I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Amy Luzar, LISW-S 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 Amy Luzar, LISW-S to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Amy Luzar, LISW-S to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Amy Luzar, LISW-S, I may revoke this authorization by providing written notice to Amy Luzar, LISW-S 19910 Malvern Rd. Shaker Hts., OH 44122 or fax at (216) 991-5472.

I agree that Amy Luzar, LISW-S may communicate with me electronically unless and until I revoke this authorization by submitting notice to Amy Luzar, LISW-S 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.

I hereby authorize the transmission of my protected health information electronically as described above.

Patient Name: _____ Date _____

Signature of Patient (if patient is 18 over) or Parent/Guardian:

_____ Date _____

Amy Luzar, LISW-S

Tele-Mental Health Informed Consent

I, _____, hereby consent to participate in tele-mental health with, _____ , as part of my psychotherapy. I understand that tele-mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to tele-mental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-mental health services are not appropriate and a higher level of care is required.

6) I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____
and my emergency contact person's name, address, phone: _____
_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian _____Date _____

Signature of therapist _____ Date _____