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Consent to Allow Cyber Communication

Name: ___________________________ MR#: _______________ DOB: ____________

I, _______________________, hereby give my permission to release/obtain information of my presence in therapy by e-mail or text. The e-mail or text will be utilized for appointment reminders or to reply to communication which I, the patient, have initiated. I understand that my records are protected under the Federal Confidentiality regulations (42 CFE Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA) an cannot be disclosed without my written consent unless otherwise provided for in the regulations.

- **I AM WAIVING THESE RIGHTS FOR THE ABOVE-MENTIONED COMMUNICATIONS.**
- **I AUTHORIZE THE FOLLOWING CYBER COMMUNICATIONS:**

  E-Mail at: ___________________________

  Text at: ____________________________

I understand that the cyber communications are NOT protected by any firewalls. I am freely waiving my rights for the purposes of my own convenience. I will not hold Lampein Marriage and Family Therapy Institute, Inc. (LMFTI hereafter) staff responsible for any breach of privacy via cyber communication. I also understand the following regarding cyber communications:

- **Communications by text and e-mail are NON-PROTECTED communications.**
- **This authorization will automatically expire 6 months from date signed.**

I may revoke this authorization at any time upon written notice to LMFTI. I acknowledge that such revocation will not be effective if LMFTI has already acted in reliance upon this authorization. A photocopy of this document is to be considered as valid as the original document. Information that is being released under this authorization may be re-disclosed. The privacy of this authorization may not be protected under the federal privacy regulations. I hereby release LMFTI from any liability which may arise as a result of the use of the information released in accordance with this authorization.

____ ____________________

Participant's Signature: Date:

____ ____________________

Participant's Signature: Date:

____ ____________________

If a Minor, Signature of Participant's Legal Representative and Role/Relationship to Minor Date:

____ ____________________

Licensed Therapist's/Counselor's Signature: Date:

____ ____________________

Supervisor's Signature: Date: