Partners for Behavioral Health and Wellness

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Phone: 216.342.4140 FAX: 440.792.4645

AUTHORIZATION TO COMMUNICATE VIA CELL PHONE, EMAIL & TEXTING

Patient name:____ DOB:___________________

Patient email address: ____

- I authorize my clinician to communicate with me using cell phone, electronic mail (email) and/or texting.
- I understand that cell phone, email and texting may not be secure, and there is a risk of the text or email being read by a third party.
- My clinician will not be held responsible for any unauthorized access to my protected health information while in transmission to me via email.
- I may revoke this authorization at any time in writing to my clinician named above.

____ ________________________

Patient Signature Date