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, & VIDEO

Patient name:_____ DOB:_____

Patient email address: _____

- I authorize my clinician to communicate with me using cell phone, electronic mail (email), texting, and electronic video.
- I understand that cell phone, email, texting, and video may not be secure, and private, and there is a risk of the communication being viewed or read by a third party.
- My clinician and Partners for Behavioral Health and Wellness, Inc. ("Partners") will not be held responsible for any unauthorized access to my protected health information and I hereby release and discharge my Clinician and Partners from any damages, claims, or other liability related directly or indirectly to use of cell phone, email, texting, and/or electronic video devices.
- I may revoke this authorization at any time in writing to my clinician named above.

_____ _____

Patient Signature Date