Consent for Electronic Communication

It may become useful during the course of treatment to communicate by email, text, or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Invictus Clinic and its staff there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages;
- Your employer, if you use your work email to communicate with Invictus Clinic;
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.
- If you are concerned about methods of communication that are more secured, please talk with Invictus Clinic staff about ways to keep your communications safe and confidential. If you are willing to communicate electronically, with the understanding that it is unsecured and that your information may be accessed or intercepted by others, please proceed with signing the consent below.

I consent to allow Invictus Clinic and its staff to use unsecured email, text, or other means of unsecured electronic communication to transmit to me the following protected health information:

- ☐ Information related to the scheduling of meetings or other appointments
- ☐ Information related to billing and payment
- ☐ Completed forms, including forms that may contain sensitive, confidential information
- ☐ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
- ☐ My health record, in part or in whole, or summaries of material from my health record
- ☐ Other information (Please Specify):

INVICTUS CLINIC

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☐ **I understand that the information to be released may include the following: diagnoses and/or treatment for alcohol, drug or substance abuse; psychological or psychiatric conditions; AIDS/AIDS Related Complex (ARC) diagnoses and treatment; HIV test results; or sickle cell anemia. I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that Invictus Clinic may not condition treatment, payment, or eligibility for benefits on my signing this authorization. I also understand that I may terminate this consent by providing written notice at any time, but that this authorization will terminate no later than when my treatment relationship with Invictus Clinic has ended.**

Email: _____

Phone:_____

_____ _____

Patient Signature Date

_____

Patient Printed Name