

Travers Counseling & Professional Services

100 N 6th Street Ste. 402 Waco, Texas 76701

Authorization for Electronic Communication

As a convenience to me, I authorize **Travers Counseling and Professional Services** to communicate with me regarding my treatment via electronic communications (email or text message) and to transmit my protected health information electronically as described below.

I understand there are risks inherent in the electronic transmission of information by email or text message:

- Such communication does not provide a completely secure means of communication.
- Any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted.
- Electronic transmission of information cannot be guaranteed to be secure or error-free.
- Data may be vulnerable to access by unauthorized third parties.

As such, **Travers Counseling and Professional Services** 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 **Travers Counseling and Professional Services** to me.

Text Communication: ☐ Yes ☐ No

Authorized phone number(s): _____

Email Communication: ☐ Yes ☐ No

Authorized email address(es): _____

Other: ☐ Yes ☐ No

Authorized service(s): _____

Your treatment does not depend on consent. You have the right to terminate or amend this agreement at any time. The use of more secure communication methods, such as messaging through your **Therapy Appointment** Patient Portal are alternatives always available if you elect to not give consent to any of the forms of communication listed below.

I understand that **Travers Counseling and Professional Services** may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to **Travers Counseling and Professional Services** 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.

Patient Name

Signature of Patient

Date

