Authorization to Receive Electronic Communications

Clients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like Building Blocks Therapy to send information to this e-mail address:

(Please print clearly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please reprint the e-mail address here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person controlling the above e-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I **do not** want Building Blocks Therapy and its Agents to communicate with me concerning the services I receive from Building Blocks Therapy via electronic communications.
* I **hereby authorize** Building Blocks Therapy and its Agents to communicate with me concerning the services I receive from Building Blocks Therapy via electronic communications including e-mail and text messages.

I understand:

* electronic communications will include sensitive health information termed Protected Health Information (PHI) under Federal regulations,
* electronic communication should not be used in the case of a need for emergency medical care,
* by providing an email address, I attest that I control access to its information,
* I may revoke this authorization at any time,
* there are inherent privacy risks associated with electronic communications including the unwanted interception of emails by unauthorized individuals,
* Building Blocks Therapy uses reasonable means to safeguard information sent electronically, and
* Building Blocks Therapy does not condition the provision of services on accepting electronic communication
* I authorize Building Blocks Therapy and its Agents to leave **voicemail** messages on this phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand Building Blocks Therapy will leave the minimum necessary information but the message may contain sensitive health information or PHI as described above.
* I authorize Building Blocks Therapy and its Agents to **text messages** to this phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand Building Blocks Therapy will leave the minimum necessary information but the message may contain sensitive health information or PHI as described above.

Client’s Representative (signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

Name of Representative (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Over for medical release)

Authorization to Release Medical Information

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Building Blocks Therapy to release the information or records to:

* CAIU
* Caregivers/Daycare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* CMU (Dauphin SCs)
* Cumberland/Perry MHIDD (Cumberland SCs)
* Physician(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Additional therapists: TMB/IDP (annual eval) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

upon request and/or as necessary for treatment.

Records authorized to be released (must specify the reason below):

* Assessments and/or evaluations
* Treatment documentation
* Complete chart
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information will be used for:

* Continuity of treatment
* Training
* Investigating an allegation of abuse
* Providing advocacy services
* Legal representation
* Verifying eligibility for services offered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This authorization will expire on the child’s 4th birthday**.

I understand that I can revoke this authorization at any time by writing to Megan Lesko, Building Blocks Therapy; PO Box 943; Camp Hill, PA 17001-0943. I understand that revoking this authorization will not affect disclosures made or action taken before the revocation is received.

I also understand that:

I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.

Federal privacy regulation will no longer apply to the information disclosed.

I am entitled to receive a copy of this authorization.

Client or Representative (signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_

Name of Representative (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature/Date/Reason for file review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if applicable)