CLIENT REQUEST AND AUTHORIZATION FOR TEXT COMMUNICATIONS

Text communications are less secure than communications sent through the US mail or other "paper" delivery forms. There is no guarantee of privacy or security of protected health information (PHI) when information is sent via text, and information is subject to more potential breaches, e.g., due to lost or stolen devices, or other intentional acts. Nevertheless, you have the right to request that your health care provider(s) communicate with you via "alternative methods," including texts. For more information about your privacy rights, please see our Notice of Privacy Practices.

Please be advised that:

- Mono County Behavioral Health (MCBH) and its supporting clinicians will make all efforts to utilize protection processes that minimize an unauthorized disclosure of PHI, however, with this authorization of PHI release, client acknowledges and accepts the responsibility of unauthorized release of PHI and agrees to hold the County of Mono, its employees, officers and agents harmless should unauthorized disclosure or release of text containing PHI should occur.
- MCBH will take reasonable steps to limit what is communicated and will not include your date of birth, social security number or other information that could make you more vulnerable to ID theft.
- MCBH will take steps to limit what information is sent to the "minimum necessary" to communicate information to you about appointments, treatment, payment, medications or other matters; we cannot send an entire copy of your medical record via text.
- Your request will not be effective until you receive and respond appropriately to a "test" text message from MCBH.
- This request for and authorization of text communication will remain in effect until you notify us in writing that you wish to revoke it.

Please provide the following information:

Name: _____ Date of Birth: _____

Mailing Address: _____

❑ **I request Text messages** (please indicate the telephone number to send text messages to):

_____

Please specify the individual at Mono County Behavioral Health (MCBH) with whom you wish to communicate via text by name or exact title/position Mono County Behavioral Health (MCBH), (e.g. "Mary Smith, LCSW" or "my case manager"):

_____

The type of information I authorize to be communicated by email is:

❑ Scheduling and appointment information only.

❑ Information about scheduling and appointments, treatment, payment, medications or other related matters.

By checking one of the boxes below and providing the answer, please select the question to be used to identify you in your test text.

❑ My favorite color:
_____

❑ My pet's name:
_____

❑ My favorite food:
_____

❑ My favorite teacher:
_____

Please read each of the following statements and acknowledge your understanding by your initials in the blank space provided:

_____ I have received a copy of Mono County Behavioral Health (MCBH) *Important Information about Agency/Client Texting and Email* and have read and understand it.

_____ I understand that text communications in which I engage may be copied and maintained in my medical record, and may be forwarded to other health care providers, including providers not associated with Mono County Behavioral Health (MCBH), for purposes of providing treatment to me.

_____ I understand and acknowledge that communications via text are not as secure as voice communications or communications via US mail or other delivery methods.

_____ I understand and acknowledge that despite the precautions taken by Mono County Behavioral Health (MCBH) to protect my privacy, there is no assurance of confidentiality of information when communicated via text.

_____ I understand that I may revoke this request and authorization at any time. Such revocation must be in writing and signed by me or my legal representative and provided to MCBH. The revocation will be effective upon receipt, but will not be effective to the extent that the requestor, recipient or others have relied upon this request and authorization.

_____ I understand that I may refuse to sign this request and authorization. Except where otherwise allowed by law, treatment, payment, enrollment and eligibility for benefits will not be conditioned on my providing or refusing to provide this request and authorization.

_____ I understand that I have a right to receive a copy of this authorization and to inspect and obtain a copy of my health information.

_____ I agree to hold the County of Mono and its employees, officers and agents harmless should unauthorized disclosure, release or access to a text containing my PHI occur.

This request and authorization shall remain in effect until _____, unless earlier revoked.

_____ _____

Signature of Client or Client Representative Date

_____

If signed by a Client Representative, please state your relationship to client

_____

(Witness signature)

Approved by: _____ *Title:*_____ *Date:* _____