Authorization for Electronic Communication

As a convenience to me, I hereby request that Presence of Mind Therapy communicate with me regarding my treatment by Presence of Mind Therapy via electronic communications (e-mail, text message, telehealth video conference). I understand that this means Presence of Mind Therapy and/or my treating providers will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications. I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Presence of Mind Therapy 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 Presence of Mind Therapy to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Presence of Mind Therapy to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Presence of Mind Therapy, I may revoke this authorization by providing written notice to Maureen Schafer owner of Presence of Mind Therapy at 208 Lenox Ave #207 Westfield, NJ 07090. I agree that Presence of Mind Therapy may communicate with me electronically unless and until I revoke this authorization by submitting notice to Presence of Mind Therapy 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. I hereby authorize the transmission of my protected health information electronically as described above.

Patient printed name

Patient signature and date