UNSECURED ELECTRONIC COMMUNICATIONS CONSENT

Client Name: _____ **Date of Birth:** __/__/____ **MRN#**_____

____(initial) **ACCEPT** By initialing the box containing "Accept" I hereby state that I have read, understood, and agree to the terms of this document and I desire and consent to receive communications electronically as stated below (e.g. text, email and/or *instant messaging, FaceTime*), and am aware that I may request a copy of this form at any time from **DMHAS**.

UNSECURED ELECTRONIC DATA CONSENT FORM

____(initial) I affirm that I have read, understood, and agree to the terms of utilizing Unsecured Electronic Communications. I understand the risks associated with the communication of unsecured electronic data transmission between **DMHAS** and me and consent to the conditions outlined herein. I agree to the instructions for communicating by unsecured electronic data transmission as outlined here, as well as any other instructions that **DMHAS** may impose to communicate using unsecured electronic data transmission.

• While the DMHAS will attempt to review and respond in a timely fashion to your electronic communication, the DMHAS cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time.

These services will not be used for medical emergencies or other time-sensitive matters.

- If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on Electronic Communication Services. ***Rather, you should take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic or calling 911.***

I agree that because of my written consent that use of unsecured electronic data transmission to communicate with me concerning non-public data is a reasonable and proper way to communicate with me.

I wish to communicate by *(please check all boxes that apply):*

Unsecure E-mail ☐ Unsecure Text ☐ Both (Unsecured Text and Unsecured Email) ☐

Email address	Text #	Recipient Name

FaceTime (DHoH Clients ONLY) ☐	Recipient Name/Number:

I agree to notify my provider if the above listed email address or phone number should change.

_____ _____
Signature of Client Date

_____ _____
Signature of DMHAS Representative Date