CENTRAL WISCONSIN MENTAL HEALTH ASSOCIATES, SC

CLIENT TEXTING INFORMED CONSENT

NAME:______________________________________ DOB:______________________

The transmission of client information by texting has a number of risks that clients should consider prior to the use of text. These include, but are not limited to, the following risks:

a. Texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Text senders can easily misaddress a text and send the information to an undesired recipient.
c. Backup copies of texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Text messages can be intercepted, altered, forwarded or used without authorization or detection.
e. Texts can be used as evidence in court.
g. Texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of texts: Therapist cannot guarantee, but will use reasonable means to maintain security and confidentiality of text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Client/Parent/Legal Guardian must acknowledge and consent to the following conditions:

a. Texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular text will be read and responded to within any particular period of time.
b. Texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
c. Texts may be printed and filed in client's file.
d. Provider will not forward client's/parent's/legal guardian's identifiable texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
e. Client/parent/legal guardian should not use texts for communication of sensitive medical information.
f. Provider is not liable for breaches of confidentiality caused by the client or any third party.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer at Central WI Mental Health Associates, SC, Attention Privacy Officer, 1699 Schofield Ave, Suite 119/120, Schofield, WI, 54476. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Authorization of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination or revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment (423CFR Part 2.35).
Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by text at this phone number:____

I understand that I am entitled to a copy of this release and the information released. Expiration: This authorization is effective for one (1) year from the date of signing or as specified by this condition stated: (no longer than one year):

_________________________________ __________ _______________________________ __________
Signature of Patient/Client Date Signature of Parent or Guardian Date

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Signature of Staff Witness Date