SAMARITAN COUNSELING CENTER

1803 OREGON PIKE • LANCASTER, PA 17601 • 717-560-9969 • FAX 717-560-9553

CONSENT FOR USE OF EMAIL AND TEXT COMMUNICATIONS

I am consenting to email and text communications between myself and the Samaritan Counseling Center, with the following understanding:

Potential Risks:

- Information transmitted may not be sufficient for a clear understanding between parties.
- Unencrypted email or text communication is **not** a HIPAA compliant form of communication. The Samaritan Counseling Center does not have encryption capabilities to maintain the procedures and protocols necessary for secure communication via email or text. There may be issues beyond the control of the Samaritan Counseling Center that could cause a breach of privacy of your confidential information. With your signature, you are affirming that you understand and are agreeing that the Center cannot guarantee any safety of the information that is discussed with you over these types of communication.
- Under no circumstances can the Samaritan Counseling Center guarantee that any email or text communication will be confidential.

I understand that the following alternatives are available to me:

- A face-to-face appointment with the clinician.
- Communication via telephone.

I understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that the Samaritan Counseling Center has acted in reliance hereon.

By my signature below, I understand that any communication via email or texting is not secure and that the Samaritan Counseling Center does not guarantee the privacy of any communication via these types of communication.

_____
Client Name

_____ _____ _____
Date of Birth of Client | Your relationship to Client (Self, Parent, Guardian, etc.). | If not Client, Print your Name

_____
Email Address

_____ _____
Client signature (or parent/guardian signature if client is a minor) | Date

_____ _____
***Signature of minor client, if minor is 14 years or older** | Date

_____
Email Address for minor 14 years or older (if different than email address above)

_____ _____
Therapist Signature* | Date

*My signature above verifies that the client received adequate explanation to make an informed decision.

Restrictions: _____

Verbal Authorization
The undersigned verify verbal authorization has been given. Please request client review form online for their informed consent.

_____ _____ _____ _____
Witness Signature | Date | Witness Signature | Date