Building Foundations Counseling Center, Inc.
A Professional Family Counseling Corporation

Authorization for Electronic Communication

I, _____ hereby request that Building Foundations Counseling Center, Inc. and my treating clinician communicate with me, and other authorized professionals and persons (must have my, or my representative's, signed Release to Exchange Information form for such professionals and persons) regarding my treatment by Building Foundations Counseling Center, Inc. via electronic communications (e-mail). I understand that this means Building Foundations Counseling Center, Inc. and/or my treating clinician will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individual identifiable information about my treatment via electronic communications. I understand there are risks inherent in the electronic transmission of information by e-mail, internet, 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, neither Building Foundations Counseling Center, Inc., nor my treating clinician shall have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communications of information by Building Foundations Counseling Center, Inc., or my treating clinician to me or other authorized professionals and persons. After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Building Foundations Counseling Center, Inc. and my treating clinician to communicate electronically with me, and authorized professionals and persons, which will include the transmission of my protected health information electronically. I agree that Building Foundations Counseling Center, Inc. and my clinician may do so until I revoke this authorization by submitting notice to Building Foundations Counseling Center, Inc. in writing.

I hereby authorize the transmission of my protected health information electronically as described above.

_____
Patient's Name (Printed)

_____ _____
Patient's Signature Date Signed

_____ _____
Patient's Representative's Signature Date Signed

_____
Representative's Relationship to Patient