C. ALLEN RUYLE, LCSW
CONSENT FOR CONFIDENTIAL ELECTRONIC COMMUNICATION

Client's Name:_____ DOB:_____

C. Allen Ruyle, LCSW, complies with HIPAA and other privacy or security laws and standards regarding the access, use, or disclosure of your protected health information (PHI). I am dedicated to protecting your privacy and indication of involvement in treatment. As such, I require your consent to communicate information (appointments, brief information, etc.) to you via electronic means including telephone, email, and/or text.
Please complete the following:

PART I

You may contact me at the following number: _____

The number is a: ☐Home Phone ☐Cell Phone ☐Work Phone

At this number, you can:
___ Leave a voice message
___ Leave a message with the person who answers
___ Text pertinent information

You may also contact me at the alternate number: _____

The number is a: ☐Home Phone ☐Cell Phone ☐Work Phone

At this number, you can:
___ Leave a voice message
___ Leave a message with the person who answers
___ Text pertinent information

Restrictions (if any):

_____

PART II

It is the policy of C. Allen Ruyle, LCSW that treatment information (i.e., treatment plans, progress notes) NOT be provided to clients through email unless encrypted and your express written consent is on file acknowledging your understanding of potential consequences to receiving said information through email (including breach by your provider, other family having access to your account, etc.).

___ I acknowledge potential risks to email communication and do not give consent to receive treatment information via electronic mail (email).

___ I acknowledge potential risks to email communication and give consent to receive treatment information via electronic mail (email) at the following email address: _____ and request only the following be provided by this means:

___ General information (i.e., appointment reminders, scheduling communication)
___ Reports, treatment plans, billing statements, etc., which contain specific details of my treatment, diagnosis, etc.

By signing below, I authorize C. Allen Ruyle, LCSW and his staff to communicate confidential information to me by the means indicated above and understand that neither C. Allen Ruyle, LCSW nor his staff is responsible for any redisclosure or accidental access by other parties based on this consent.

_____ _____
Client Signature Date

_____ _____
C. Allen Ruyle, LCSW/Witness Signature Date