PORTER STARKE SERVICES
Health • Balance • Hope

Marram Health Center
Your partner in total health.

Authorization for Electronic Communication

This form does not apply to verbal telephone or fax communication, or appointment reminders sent via verbal phone call or text.

Client Name (please print): ____ Date of Birth: __________________________

Client Address: ____City/State/Zip: _________________________

Client Account Number: ______________________________

Please mark one box:

❑ **I request and give permission** for Porter-Starke Services and/or Marram Health Center to communicate with me electronically via text, email or other electronic means as is necessary to provide my treatment and other business needs related to the services I receive. I understand these communication methods are using **unsecure text messaging and/or unsecure email**. I understand that by providing my information and requesting electronic communication, that I am accepting the risk for a possible unauthorized disclosure. I understand if I share my phone account or email account with another person outside of Porter-Starke/Marram, that person would be able to view my private health information. If my phone # or email address below changes, I am responsible to update that information and submit an updated Authorization for Electronic Communication form. If my information is disclosed without my authorization, or my device(s) is/are lost or stolen, I will not hold Porter-Starke Services or Marram Health Center responsible for any disclosure that may occur.

❍ **Text/Phone Number:** (_______) ____________________ ❍ **Fax Number:** (_______) ____________________

❍ **Email:** ____

By signing below, I attest that the text/phone number, fax number or email address provided above solely belongs to me, or I have given permission to share with another person. I understand that secure communication methods are available to me but I am declining to use the secure communication method, and am choosing to use unsecure electronic communication.

I fully understand that my medical record contains confidential physical, mental health, substance abuse, and/or HIV/AIDS information compiled in the course of my treatment. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, as required by law. I understand that records not protected by Federal confidentiality rules (42CFR Part 2) may be subject to re-disclosure by the recipient and may no longer be protected by 42CFR Part 2, Federal, or State law. I understand that I cannot be required to sign this authorization as a condition for having treatment provided or obtaining payment for the same.

Date, event or condition this authorization expires:______________________. If no date, event or condition is specified, this authorization expires 60 days after services have been terminated or when all financial responsibilities have been satisfied. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written or oral revocation request to the Health Information Department.

❑ **I decline** for Porter-Starke Services and/or Marram Health Center to communicate with me electronically via text, email or other electronic means as is necessary to provide my treatment and other business needs related to the services I receive.

Client/Guardian Signature: ____Date: ______________________________

Relationship to Client: ____