Authorization to Exchange Information Via Electronic Means between Provider and Client

Transitions-Mental Health Association

Inspiring hope, growth, recovery and wellness in our communities.

Client Name _____ Date of Birth _____

If communication is with Guardian or legal representative (name and relationship) _____

Client's Cell Phone Number and/or Email _____ Cell Phone Carrier (so we can text from computer) _____

The following providers may exchange health related information with me via text message and email:

Shawn Ison, Fernando Vasquez, Vivian Soul, Maria Perez, Zandra Alfaro-Olea, Laura Gaisie, Linda Quesenberry, Elissa Feld

_ Provider names and roles (Clinician, Case manager, Nurse, etc.)

NOTE: Signing this document authorizes the exchange of health information between client and provider via text messaging and via e-mail.

Please read all of the cautions below:

- Communication by text and/or e-mail may not be secure and private. Understanding this risk, you are voluntarily requesting this form of communication.
- If your situation is important or time-sensitive and needs immediate attention, do not rely on text message or e-mail. Electronic communications will only be returned during business hours, Monday through Friday, 8:00 a.m. to 5:00 p.m. (excluding holidays). If you have sent an electronic message to your provider and have not had a response within 48 hours, please contact your provider by phone.
- Communication by text will be limited to scheduling and logistics only. If communication is initiated, which includes clinical information, TMHA Staff is responsible for switching to in-person or phone (voice) discussion.
- Electronic communication will not be used for crisis services or to communicate clinical information. **If you are having a crisis, Call 911 or call TMHA hotline at (800) 783-0607.**
- If you change your phone number or e-mail address, you must notify the Health Agency.

I request and authorize the San Luis Obispo County Health Agency to exchange limited information with me about my healthcare via text messaging and e-mail. I have read and understand this Request and Authorization to Share Information via Electronic Means between Provider and Client.

Client or Legal Representative Signature _____ Date _____

Print Client or Legal Representative's Name _____

For Staff Use Only:

Client ID#: _____ **Date Received:** _____

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