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617-547-0909
kinnect@gmail.com

AUTHORIZATION TO COMMUNICATE BY EMAIL AND/OR TEXT MESSAGING

I, _____ hereby authorize PACT, and
Dr. Joyce Maguire Pavao, to communicate

Person Served/Guardian

with me by email and/or text / "SMS" messaging ("texting"). I understand the inherent risks associated with communicating with my provider at PACT via email and/or texting. I have discussed such risks with my provider, and all of my questions have been answered to my satisfaction.

I understand that PACT generally discourages communication with clients via email and/or texting because such modes of communication may not be the most secure methods of communication. I understand that while PACT's general policy is to attempt to restrict emails and/or text messaging communications to basic, non-sensitive correspondence, such as appointment scheduling and reminders, such email and/or texting correspondence may nevertheless contain sensitive personal health information, including but not limited to diagnosis (including mental health diagnosis), medications, reasons for seeking support and other such sensitive or confidential information relating to the services provided by. I understand that because I am authorizing personal health information to be sent via email and/or texting, which are not secure methods of communication, confidentiality with respect to such communications cannot be ensured.

I understand that if my email and/or cell phone number changes, I must notify PACT immediately. I also understand that I can revoke this authorization at any time by submitting a handwritten request to my provider or to the HIPAA Privacy Officer, and that and that this authorization remains valid until such revocation. I have the right to revoke such authorization, except to the extent that PACT has taken action in reliance on this authorization. I further understand the potential for such communications to be subject to redisclosure by third parties that are not subject to this authorization and therefore such information may no longer be protected, even after revocation.

I understand that emailing and texting must not be used in the event of an emergency because emails and text messages may not be monitored on a 24-hour basis. In the case of an emergency, I understand that I must call 911, and I must not rely on email or texting correspondence for assistance.

RELEASE. By signing this authorization, I understand that communicating with PACT via email and/or texting carries with it inherent risks, including but not limited to inadvertent disclosure of my protected health information. I hereby release and forever discharge PACT and its employees, contractors and agents, from and against any and all claims, demands, rights, or causes of action, present or future, whether known or unknown, anticipated or

unanticipated, and resulting from or arising out of, or incident to, use of communicating via emailing and/or texting, including but not limited to claims under state and federal privacy laws. This release is not being required by PACT as a condition of the provision of treatment, payment, enrollment or eligibility for benefits and is not intended to constitute a waiver of my rights that cannot by law be waived.

AUTHORIZATION

Person-Served Name: _____

Please Print

Person-Served/Legal Guardian Signature:

PACT: _____

Authorization to Communicate By:

Email (_____ @ _____ . _____)
Email Address

Text Messaging / SMS _____
Cell Phone Number

Date: _____

7/28/03
Reviewed 6/09
Reviewed 6/10
Reviewed 8/11
Revised 4/12
Reviewed 6/12
Revised 10/12
Revised 1/18
Revised 4/11/18
Revised 2/5/19