Name of Client/Patient Date of Birth (mm/dd/yyyy) Phone Number

Address City, State, Zip

Client/Patient request that the Department contacts them in any of the following forms:

Phone:

Encrypted Email:

Unencrypted Email

The Department may send Public Health Information (PHI) in an unencrypted email to Client/Patient if Client/Patient has reviewed and agreed to the following language:

Unencrypted emails are not secure during transmission, which means that PHI could be accessed by a third party while in transit. The Department is not responsible for any disclosures of PHI when provided in an unencrypted email.

Text Messages without PHI

The Department may send text messages to Client/Patient that **do not** contain PHI if Client/Patient has reviewed and agreed to the following language:

Text messages are not secure during transmission, which means that information could be accessed by a third party while in transit. The Department is not responsible for any disclosures of information when provided in a text message.

Signature: Date:

If this form is completed by a parent/guardian/authorized agent on behalf of the client/patient, complete the following:

Parent/Guardian/Authorized Agent’s Name (please print)

Please check one of the following:

Parent/Guardian

Authorized Agent

|  |
| --- |
| For Office Use Only If Records Requested to be Inspected:  Name of Inspecting Person:  Records Released for Inspection: |