E-MAIL/TEXTING AUTHORIZATION

E-mail and texts have become an increasingly popular mode of communication between healthcare providers and patients. Emails sent to “Worth Therapy” at worththerapy@gmail.com are only reviewed by Dr. Kathryn Sternweis-Yang. However, it’s important that you acknowledge that I cannot guarantee the security of any information sent or received via e-mail/text. Therefore, outbound emails/texts are intentionally brief and practical, versus clinical. They generally involve logistical matters such as scheduling and appointment changes. I am happy to provide email/text appointment reminders if you would like. However, I do not conduct therapy via email/texts. Email/texts should not be used as a means to contact me in an emergency.

Please check one of the below options:

|  |  |
| --- | --- |
| ☐ | I do NOT authorize e-mail/texting communication with Worth Therapy |
| ☐ | I have read and understand the above information, and ONLY authorize **e-mail** communication with |
|  | Worth Therapy at the below e-mail address(es) |
| ☐ | I have read and understand the above information, and ONLY authorize **text** communication with |
|  | Worth Therapy at the below phone number(s) |
| ☐ | I have read and understand the above information, and authorize BOTH e-mail and text |
|  | communications with Worth Therapy at the below e-mail address(es) and phone number(s) |

|  |  |  |
| --- | --- | --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I understand this authorization is valid until (indefinite if left blank) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , that I may, via written request, withdraw my authorization at any time, and that I have a right to receive a copy of this authorization form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient’s Name (Please Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date