Rita Bryce, JD, LISW
Child, Adolescent and Adult Therapist

Authorization for Electronic Communication

As a convenience to me, I _____ request that Rita Bryce communicate with me regarding my treatment via electronic communications (including internet, video, phone, e-mail or text message), hereinafter referred to as "electronic communications." I understand that my protected health information, including videoconferencing, appointment information, diagnosis, medications, progress, and other individually identifiable information about my treatment will be communicated to me through electronic communications.

I understand that the laws and regulations which apply to the provision of mental health services in Ohio also apply to mental health services provided through electronic communications.

I understand that therapy sessions will be primarily conducted by video. I understand that texting and email will not be used for therapeutic issues but may be used for scheduling.

It is my responsibility to maintain my privacy and to use equipment which is reliable for electronic communications. Should electronic communications be interrupted, Rita Bryce will then attempt to contact me through the phone number I provide to reschedule the appointment. I authorize Rita Bryce to leave voice messages or messages with a third party at the number provided regarding scheduling.

I understand that if there is an immediate need for direct service that it is my responsibility to contact a provider in my area such as PsychBC or Mobile Crisis (216-623-6555 or Text "4Hope" to 741741.) I understand that in the case of an emergency or crisis I must call 911 or go to the nearest emergency room.

I understand there are benefits and risks involved in this service, including technological limitations, described below, and that I may find in-person treatment more effective.

I will not record any videoconferencing sessions. I will inform Rita Bryce if any other person can hear or see any part of our session.

I understand there are risks in electronic communications, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I understand that protected health information transmitted through electronic communications pursuant to this authorization may not be encrypted.

As the transmission of information through electronic communications cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, I understand that Rita Bryce shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with electronic communications.

I understand that there are risks to entering private information on a shared or public access computer and I will not auto-fill user names or passwords. I also understand that I should consider employer policies when using work-related computers for personal communications.

I understand that not all insurance companies provide benefits for services delivered by electronic communications.

I hereby expressly authorize Rita Bryce to communicate with me through electronic communications, which will include the transmission of my protected health information. I understand that in the event I no longer wish to receive electronic communications I may revoke this authorization by providing written notice to Rita Bryce at https://ritabryce.com/contact/

I authorize Rita Bryce to transmit protected health information to my insurance company and any other entities or individuals permitted by law to have access to such information.

I hereby authorize the transmission of my protected health information electronically as described above.

_____

Print Patient/Client Name

_____

Signature of Patient/Client Date