RIVER CAIRN COUNSELING

Authorization for Electronic Communication

As a convenience to me, I hereby request that River Cairn Counseling communicate with me regarding my treatment by River Cairn Counseling via electronic communications. I understand that this means River Cairn Counseling will transmit my protected health information (PHI) such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any PHI transmitted via electronic communications pursuant to this authorization may not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, River Cairn Counseling shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information between River Cairn Counseling and myself.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize River Cairn Counseling to communicate electronically with me, which will include the transmission of my PHI electronically. I understand that in the event I no longer wish to receive electronic communications from River Cairn Counseling, I may revoke this authorization by providing written notice to River Cairn Counseling at 5539 S. 27, Suite 104, Lincoln, NE 68512.

I agree that River Cairn Counseling may communicate with me electronically unless and until I revoke this authorization by submitting notice to River Cairn Counseling in writing. This authorization does not allow for electronic transmission of my PHI to third parties and I understand I must execute a separate authorization for my PHI to be disclosed to third parties.

I hereby authorize the transmission of my PHI electronically as described above.

_____

Client Name

_____ _____

Signature of Client Date