Balanced

Authorization for Technological Communication

I hereby give consent that Balanced communicate with me regarding my treatment by Balanced via electronic communications (i.e., email, video chat via Teams and other forums, etc.). I understand that this means Balanced and/or my treating providers will transmit my protected health information 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 protected health information transmitted via electronic communications pursuant to this authorization will not be always 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, Balanced 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 by Balanced to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Balanced to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Balanced, I may revoke this authorization by providing written notice to Balanced at 100 Hillcrest Drive, Suite C, Washington, IL, 61571, or fax at (309) 444-2866.

This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

If you or your child is having thoughts to harm self or others, please do not communicate this to me in a text/email/Facebook message. Go to the emergency room or call 911 as needed.

Name_____

Signature of Patient (12 or older) _____ **Date**_____

Signature of Guardian (If Applicable) _____ **Date** _____

Witness/Staff _____ **Date** _____