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

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