



Electronic Communication Consent

The following summarizes the information you need to determine whether you wish to supplement your experience at our practice by electronically communicating with Aspire clinicians and staff.

General Considerations

- Email will be treated with the same degree of privacy and confidentiality as other medical records.
- Standard email services are not secure and do not meet the security requirements of HIPAA for protected health information. Email messages are not encrypted and can be intercepted by unauthorized individuals.
- Your email address will not be used for external marketing purposes without your permission. You may receive a group emailing from the practice; however, the recipients email addresses will be hidden.

Provider Responsibilities

- Staff will attempt to confirm your email address by requesting a return response to all email messages.
- Your provider may route your email messages to other members of the staff for information purposes or for expediting a response. Designated staff may receive and read your email.
- We will attempt to respond to your email message within 2 business days (Monday – Friday, non-holidays). If you do not receive a response from the practice within 2 business days, please contact the practice by phone.
- Copies of emails could be incorporated into your medical record. You should retain electronic correspondence for your files.

Client Responsibilities

- Email should not be used for emergencies or time-sensitive situations. In the event of an emergency, immediately call 911. For time-sensitive situations, contact the practice by phone.
- Please arrange for an office appointment if the issue is too complex or sensitive to discuss via email.
- Please include your full name and the topic or question in the subject line.
- Please acknowledge that you received and read the message by return email to the sender.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with Aspire. I consent to electronic communication via non-secure email services. I understand that I may revoke my consent to communicate electronically at any time by notifying the practice in writing at the above address. Revocation will not affect actions my therapist has taken in reliance on my consent.

I release my provider and Aspire Counseling Group, PLLC from any and all liability that may occur due to electronic communication over a non-secure network and agree to comply with the client responsibilities stated above.

CLIENT (Or Parent/Guardian if Client is under 18 years of age)

Client Authorized Email Address (Please print)

Client Name (Print)

Client Signature

Date