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**AUTHORIZATION TO USE UNENCRYPTED EMAIL OR TEXT MESSAGES
TO COMMUNICATE PROTECTED HEALTH INFORMATION**

Electronic mail (email) or cell phone text messages are forms of communication that may be used on rare occasion between you and your therapist. Dr. Hiltz wants to make sure you know that neither email communications nor text messages between you and your therapist are encrypted and therefore are not secure communications.

If you elect to communicate from your workplace computer, you also should be aware that your **employer** and its **agents** may have access to email communications between us. Finally, email communications and text messages may become a part of your (or your child's) confidential psychological record.

Incoming email communications and texts are discouraged except for the exchange of the most basic and brief information, such as requesting available appointment times or location information. Email and texts are neither private nor timely, since Dr. Hiltz is usually in session, or may be traveling, and may not see your email until the next day.

Dr. Hiltz may, at your request, send links to you by e-mail or text for additional information or resources. However, electronic exchange of private information (such as information usually discussed in a therapeutic environment) is strongly discouraged. Such information is best communicated face to face for protection of your privacy, your relationship with your therapist, and your therapeutic progress. If such information must be communicated prior to your next appointment, please do so by calling Dr. Hiltz at her office.

If you have emailed Dr. Hiltz and have not received a response, and are concerned that your message was not received, please call her office during regular business hours. **EMAIL COMMUNICATION SHOULD NEVER BE USED IN THE CASE OF AN EMERGENCY OR FOR URGENT REQUESTS FOR INFORMATION OR HELP.**

This authorization may be revoked at any time and must be done in writing. It is understood that the revocation will not apply to information that has already been released based on this authorization. Dr. Hiltz retains the right to discontinue the option of electronic mail or texts at any time.

This authorization is valid while in a treatment relationship with
Dr. Nicolee Hiltz

If you agree to the foregoing terms, please indicate your acceptance by completing the information below and signing the form. Your signature indicates that you accept the terms and conditions outlined above.

ACCEPTED (I prefer to sometimes exchange information by email or text)

NOT ACCEPTED (please do not email or text me)

Printed Name of Patient: _____ DOB ____/____/____

Signature of Parent/Guardian or Adult Patient: _____ Date _____

Printed Name of Individual completing form: _____

If accepted, I authorize the occasional use of

Email: _____

Cell # for Texts: _____