CANA
Center for Africans Now in America

Consent for E-Mail/Video/Audio Communication **Form 7**

This form authorizes your CANA staff/therapist to release and/or exchange protected information from your clinical record using electronic mail (e-mail) when you complete and sign it.

Name - Client: _____ DOB: _____

Address- Client: _____

Email Address- Client: _____

Other Caregivers: _____

(Note: Minors- Parents/Guardians must sign this consent form in order to release the client PHI form.
(Adults: Caregivers must be on file and also sign for the release of the client's PHI form.)

For Your Information:

- E-mail can be immediately broadcast globally and be received by many intended and unintended recipients, therefore, e-mail is not a safe means of communication.
- Messages transmitted via e-mail may not be read timely. Send urgent messages by phone other means to avoid delays.
- E-mail messages can be sent to other recipients without the original sender's permission or knowledge.
- E-mail may be modified and is easier to falsify than handwritten or signed documents.
- E-mail with information about a client's diagnosis and/or treatment does not meet the confidentiality of the client's medical record.
- In litigation, emails are discovered by all possible means.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and may no longer be protected by the HIPAA privacy rule. You have the right to revoke this authorization, in writing, at any time by sending such written notification to CANA address. Your revocation will not be effective to the extent that CANA staff have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.

_____ (Initials) I (we) understand the assumptions stated above and understand that e-mail is not a secure means of communication. I am aware that the provider may decline to communicate through e-mail based upon the nature of the medical information. I give permission for CANA to use electronic mail as a means of communication regarding my care. I understand that I may withdraw this authorization at any time by notifying CANA administrative staff or my therapist in writing.

AUDIO/VIDEO RECORDING

CANA works with schools, has a training and internship focus, and the therapists from CANA regularly participate in special education behavior observations and reports, professional clinical consultations and internships. Our clinical supervisor and clinical trainees regularly review reports, review tape recorded therapy sessions, and discuss client care. The purpose of these consultations is to aid in providing the best possible evidence-based clinical care. Those participating in the consultations and internships are bound by state and federal requirements to maintain client confidentiality. These tapes are not accessible to anyone outside of CANA team, and any other use of the tape or portions of the tape will require additional written permission from the client(s).

_____ (Initials) I (we) understand that my (our) assessment and therapy is private and that no one can observe or record sessions without my consent. I give permission to have counseling sessions video or audio taped for the purpose of clinical consultation. I understand that any recordings used for the purpose of clinical consultation will be erased within 1 month after the date of clinical review. I understand that I can withdraw this permission at any time, and that I have the right to refuse taping or ask my therapist to turn off the tape at any time. I understand there will be no penalty to me if I refuse to give permission or end taping. I also understand that all or any part of the tape will be erased at my request.

Client Signature: _____ Date: _____ Client Signature: _____ Date: _____

Client Signature: _____ Date: _____ Client Signature: _____ Date: _____

Client Signature: _____ Date: _____ Witness: _____ Date: _____