Therapy Authorization for Electronic Communication

I hereby authorize **EVEREST INSTITUTE, LLC** and any individual provider I may see within the agency to communicate with me regarding my treatment by **EVEREST INSTITUTE, LLC** via electronic communications for any purpose including, but not limited to appointment reminders and therapeutic services via phone/video. I understand that this means **EVEREST INSTITUTE, LLC** and/or my treating providers will transmit my protected health information such as information about my appointments 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 phone or video, 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 may or may not be 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, **EVEREST INSTITUTE, LLC** 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 **EVEREST INSTITUTE, LLC** to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize **EVEREST INSTITUTE, LLC** to communicate electronically with me, I hereby expressly authorize **EVEREST INSTITUTE, LLC** to communicate electronically with me, at this e-mail______________________ or text using this #_______________________, 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 **EVEREST INSTITUTE, LLC**, I may revoke this authorization by providing written notice to **EVEREST INSTITUTE, LLC** to **schuplin@ccaiowa.com** or fax at 1-515-412-5123.

I further expressly authorize **EVEREST INSTITUTE, LLC** to provide therapeutic services to me via the electronic platform of their choosing (e.g., Skype, telephone, etc.). I agree to share all requested contact information and account contact information (e.g., contact number, username, etc.) for any such platform in a timely manner so as to not delay the provision of therapeutic services as recommended by my provider(s).

I agree that **EVEREST INSTITUTE, LLC** may communicate with me electronically unless and until I revoke this authorization by submitting notice to **EVEREST INSTITUTE, LLC** in writing. 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.

I hereby authorize the transmission and receipt of my protected health information and/or therapeutic services electronically as described above.

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Patient Name

____ ____________________ ______________
Signature of Patient/Guardian Relationship Date