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| Linda Garcia-Rose & Associates ***Transformative Psychotherapy*** |
| **Linda Garcia-Rose LCSW and Associates PLLC** |

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**81 Worth Street, New York, New York,** **10013**

**Patient Notification Policy and Consent**

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Protecting your private information is not only our responsibility, it is our commitment to you.**

In order to ensure that patients receive time-sensitive information and other informational healthcare messages, Linda Garcia-Rose LCSW and Associates PLLC, as the provider of psychotherapy (“LGR&A”, “we,” “us” or “our”) send notifications to patients who opt-in to receive such notifications. If you (patient is referred to herein as “you,” “I,” “me,” “my,” “yourself,” and “your”) choose to sign this consent and opt-in to receive such notifications from us, **LGR&A will not impose a separate charge** for these notifications; however, depending on the terms and conditions of your carrier contract or other similar contract, fees and/or restrictions may be imposed upon you for receiving notifications from LGR&A. Please contact your carrier or other similar company about such fees and/or restrictions prior to providing your consent herein to such notifications from us.

It is important to note that certain communications, including, without limitation email and text messages, which may contain your protected health information (“PHI”), are not invariably secure since certain communications can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission. In compliance with the Health Insurance Portability and Accountability Act (“HIPAA”), **we are required by law to maintain the privacy and security of your PHI.** In addition, pursuant to the HIPAA Privacy Rule and Provider’s Notice of Privacy Practices, **we will not use and/or disclose your PHI without your explicit written authorization,** except as permitted by law for the purposes of payment, treatment and health care operations. Furthermore, when we are authorized and/or permitted to use and/or disclose your PHI, we will limit the use and/or disclosure of your PHI to the **minimum amount necessary** to accomplish the intended purpose of the use and/or disclosure of your PHI.

If you choose to have Provider disclose your PHI to an individual or entity other than yourself, you must properly complete Provider’s HIPAA Authorization Form, which is available upon request. **You have the right to revoke this consent by providing written notice of revocation** to the Privacy Officer, Herbert Williams (609-558-8807), at LGR&A. The revocation will become effective on the day the Privacy Officer receives the revocation of the consent, and any prior notification from LGR&A will not be subject to such revocation of the consent.

I, the undersigned, hereby consent to receive notifications from LGR&A, which notifications may include my PHI, by the following methods of communication that I indicated below, with a full understanding of the risks involved with such notifications from LGR&A, and I agree to assume all responsibility for informing LGR&A in writing of any changes to any of the methods of communications that I indicated below and for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable, and I further agree that LGR&A shall not be held liable for any unauthorized disclosures of my PHI to a third party through any of the methods of communication I authorized below or for any fees and/or restrictions that may be imposed upon me for receiving notifications from LGR&A:

Mobile Device\*: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initals \_\_\_\_\_\_\_

Other telephone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initals \_\_\_\_\_\_\_

Other telephone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initals \_\_\_\_\_\_\_

Text Message\*: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initals \_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initals \_\_\_\_\_\_\_

\*standard message rates, data rates, and/or restrictions may apply, and by consenting to receive notifications from LGR&A you agree to be solely responsible for all message fees and/or data fees that you incur from receiving notifications from LGR&A.

Patient/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_