NAME_____ DATE_____

Information Concerning and Acknowledgment of Informed Consent to Communicate Via Email or Text

Email or Text: Your Clinical File will include either an annotation of or a copy of all email or text communications sent to or received by the Provider in connection with your therapy. There are limitations and risks in connection with the use of email or text communications, including but not limited to privacy, confidentiality, and related limitations and risks.

Please also see the document entitled, "Client Information and Acknowledgment of Informed Consent to Treatment", for additional information and disclosures.

Consent: By my signature below:

a. I hereby give my informed consent to communicate with Debra K. Sowald, Psy.D. via email or text;

b. I understand that I have the right to refuse or withdraw the informed consent given above;

c. I acknowledge that I have read and understood all information contained herein and that I have been given an opportunity to ask questions concerning this document;

d. I acknowledge that I have been given a signed copy of this document.

Signature of Client: _____

Date: _____

Signature of Parent, Guardian or
Responsible Party of a Client who is a Minor:_____

Date: _____

Client Information:

Name of Client:_____
Last First Middle

Other Possible Names:_____

Date of Birth: _____Phone: _____

Address: _____

City: _____ State _____ Zip Code: _____