

# CONSENT TO USE OF ELECTRONIC COMMUNICATION

***Aaron K. Potratz, LPC MA CADC-I***

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Beaverton, OR 97005

(971) 222-8166

## **CONDITIONS FOR USE OF Electronic Communication**

Aaron K. Potratz will use reasonable means to maintain security and confidentiality of electronic communication information sent and received. You must acknowledge and consent to the following conditions:

1. Electronic communication is not appropriate for urgent or emergency situations. Healthcare providers will respond within 3 working days. If you have not received a response after 3 days you may call (971) 222-8166 to speak directly with Aaron.
2. Electronic communication should not be used for communications regarding sensitive medical conditions such as sexually transmitted diseases, HIV/AIDS, spouse or child abuse, chemical dependency, etc.
3. Electronic communications related to health consultation will be recorded in your medical record, just as telephone calls have been in the past.

## **RISKS OF USING Electronic Communication**

Transmitting information by electronic communication has risks that you should consider. These include, but are not limited to, the following:

1. Electronic communications can be intercepted, altered, forwarded or used without authorization or detection.
2. Electronic communications can be circulated, forwarded and stored in paper and electronic files.
3. Electronic communication senders can type in the wrong E-mail address.
4. Electronic communications may be lost due to technical failure during composition, transmission and/or storage.

## **CLIENT ACKNOWLEDGEMENT AND AGREEMENT**

I have read and fully understand the information in this authorization form. I consent to the Electronic Communication conditions and agree to abide by the guidelines listed above. I further understand that this Electronic Communication relationship may be terminated if I repeatedly fail to adhere to these guidelines. I understand and accept the risks associated with the use of unsecured Electronic Communications. I further understand that, as with all means of Electronic Communication, there may be instances beyond the control of the family and the health care provider where information may be lost or inadvertently exposed, such as during technical failures, acts of God, acts of war and so forth.

By signing below, I acknowledge the privacy risks associated with using Electronic Communications and authorize Aaron K. Potratz to communicate with me or any minor dependent/ward for purpose of mental health and/or substance use advice, education, and treatment.

Signature of Client/Participant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian/or  
Authorized Representative (if required) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Therapist/Witness \_\_\_\_\_ Date \_\_\_\_\_