SOLUTIONS
BEHAVIORAL HEALTHCARE PROFESSIONALS

Moorhead, MN 56560 891 Belsly Blvd. Ph:. 218-287-4338 Toll Free: 866-455-6417 Fax: 218-287-5928
Waite Park, MN 56387 423 Great Oak Dr. Ph: 320-281-5305 Fax: 320-281-5306
Fergus Falls, MN 56534 1806 Fir Ave E. Ste. 200 Ph: 218-998-2992 Fax: 320-323-4357
Alexandria, MN 56308 512 30TH Ave. E. Ste. 100 Ph: 320-762-5411 Fax: 320-762-0829
Detroit Lakes, MN 56501 1104 West River Rd. Ph: 218-844-6853 Fax: 218-844-6854
Fargo, ND 58103 1126 Westrac Dr. Ph: 701-412-2973 Fax: 701-237-4407

Client Name:	**Client Date of Birth:** ____/_____/_____	**Client Chart Number:**

INFORMED CONSENT FOR ELECTRONIC COMMUNICATION

Because electronic means of communication are sometimes more efficient and accessible than traditional telephone or postal services, SOLUTIONS has made available options, to enhance efficiency and overall customer care.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. As with any electronic service, there are possible risks. In very rare instances, security protocols could fail, causing a breach of privacy of personal information.
By signing this form, I understand that:

- The laws that protect privacy and the confidentiality of medical information also apply to any information gathered at the point of intake, and that no information obtained which identifies me will be disclosed to researchers or other entities without my consent.
- I have the right to withhold or withdraw my consent to the use of electronic communication, without affecting my right to future care or treatment.
- SOLUTIONS is not liable for someone other than me, accessing the account (ie: email or text) I have provided to SOLUTIONS.

I am requesting the following methods of electronic communication:
_____ **APPOINTMENT REMINDER TEXTS: _____ PHONE SERVICE CARRIER: _____**
(please note that although most companies do not, some companies may charge for this service; SOLUTIONS is not responsible for any charges incurred from receiving electronic communication)

_____ **EMAIL COMMUNICATIONS (used only for INTAKE or with specific provider request/approval) :**
Email Address: _____@_____.____

Patient Consent To the Use of Electronic Communication:
I have read and understand the information provided above regarding the use of electronic communication, and all of my questions have been answered to my satisfaction. I hereby give my informed consent and request to use the electronic communication as specified above.

Please use the following e mail addresses when communicating with the Intake Department: intakemhd@solutionsinpractice.org

See Minnesota Statutes Chapter 325L, Uniform Electronic Transactions Act and North Dakota Century Code Chapter 9-16, Electronic Transactions.

a.) A record or signature may not be denied legal effect or enforceability solely because it is in electronic form.
b.) A contract may not be denied legal effect or enforceability solely because an electronic record was used for its formation.
c.) If a law requires a record to be in writing, an electronic record satisfies the law.
d.) If a law requires a signature, an electronic signature satisfied the law.
(This Informed Consent for Electronic Communication form will be kept in the medical record)

Signature of Client or Parent/Guardian:	**Printed Name of Signer:**	**Date of Signature:** ____/_____/_____