
Opt-in Consent: Client Preferred Communication Practices
(beyond HIPAA/HITECH/CARES Privacy Limits)

Santa Cruz County Behavioral Health Services (BHS) strictly adheres to Health Insurance Portability Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH Act) and 42 Code of Federal Regulation (CFR), Part 2/Coronavirus Aid Relief and Economic Security Act (CARES) compliance rules and regulatory limitations to protect your personal health information when shared electronically. Our regular privacy protection practices at SCCBHS include using electronic systems that incorporate network and software security protocols to protect the confidentiality of patient information. Measures are used to safeguard the data and to ensure its integrity against intentional or unintentional corruption. We utilize HIPAA compliant electronic telehealth tools, specifically Doxy.me and Microsoft TEAMS for clinical services. In addition, we encrypt/protect personal identifying information when leaving phone messages and sending emails and do not utilize electronic communication applications, such as texting and FaceTime apps.

We are aware that these privacy compliant practices may be more restrictive than you prefer. BHS aims to remove communication barriers, and will customize our services if possible, to meet your communication needs. By doing so, we cannot guarantee the security of communications over the internet or via cellular communication. Although it is unlikely, there is a possibility that information included in an email or text message can be intercepted/hacked and read by other parties besides you.

The purpose of this form is to inform you of the risks and benefits to less-restrictive communication and to provide the choice of Opting-In for more flexible information sharing practices with your BHS provider. Your Opt-In consent is voluntary and can be withdrawn at any time by filing a written revocation request with BHS Quality Improvement at AskQI@santacruzcounty.us or by mail at 1400 Emeline, Bldg. K, Santa Cruz, CA 95060. You can modify your Opt-In consent at any time by completing and submitting a new form with your BHS treatment provider, which will make the previously signed and dated Opt-In consent form invalid.

By completing and signing this form, I hereby ACKNOWLEDE and AGREE as follows:

1. I understand that some electronic means of communication can be more efficient and accessible than traditional telephone or mail service, yet there may be some risk to my health information being seen by others, such as with text messages, emails and/or voice mail messages.
2. I understand that phone applications for texting, FaceTime, email and voicemail are not generally encrypted and may not protect my personal information from being accessed by others if they obtain my phone (name, phone number, email address and possible health care information).

3. I understand that the use of HIPAA secure texting applications, such as Signal, are recommended when communicating with my provider.
4. I understand that for privacy, it is recommended that clinical treatment and care information not be shared through the use of electronic communication (texting, email, voicemail content), and phone call /FaceTime services with my provider should be conducted in a private setting so others cannot overhear our conversation.
5. I understand that BHS will take reasonable steps to ensure the security of these communications but cannot and does not guarantee that communications will not be intercepted, misdirected, or undelivered, and BHS is not liable for third-party interception of the email and cellular phone number provided below.
6. I agree that my BHS Provider/Team may contact me via the below email address in an **unencrypted** method for non-emergency matters. These communications may include specific information relating to my healthcare provider, health conditions, and treatment. [Initial here: _____]
7. I agree that my BHS Provider/Team may contact me via a text message at the below phone number for non-emergency matters. These communications may include specific information relating to my health conditions, and treatment. [Initial here: _____]
8. I agree that my BHS Provider/Team may contact me via a telephone at the below phone number for non-emergency matters and leave personal identifying information in a voicemail. These communications may include specific information relating to my healthcare provider, health conditions, and treatment. [Initial here: _____]
9. I understand that email and text communications are not appropriate in emergency situations, and in the event of an emergency, I will call 9-1-1.

I understand that I may withdraw my consent to use unencrypted email, text and/or identifiable voicemail at any time. Also, I may modify my consent by submitting a new form, which will void the previously signed and dated form. I have read and understand the information provided above regarding the use of electronic communication, and all my questions have been answered to my satisfaction. I hereby consent to **Opt-In** to the use of less restrictive electronic communication with my treatment provider, as identified with my initials above for texting, unencrypted emails and/or personal information left in voicemails. I hereby request and authorize BHS to use the following electronic means to communicate information with me:

Email Address: _____

Cellular Phone Number: _____

Client Printed Name: _____ DOB: _____

Guardian Printed Name (if applicable): _____

Client Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____