THERAPY DALLAS

Psychological Services for Children, Adolescents, and Adults
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E-MAIL AUTHORIZATION

Although e-mail has become an increasingly popular mode of communication between healthcare offices/providers and patients, it's important you acknowledge that our office cannot guarantee the security of any information sent or received via e-mail. For this reason and others, our office aims to keep outbound e-mails relatively brief, and pertaining to practical (rather than clinical) matters. Please note that our therapists do not conduct therapy via e-mail, and cannot respond to urgent matters received by e-mail.

E-mails sent to info@therapydallas.com will be received and managed by our Office Manager, who will either respond directly to you (if the message pertains to non-clinical issues), or relay your message to your therapist (in the event your message pertains to clinical issues).

E-mail is not a foolproof means of communication and we cannot be responsible for misdirected e-mails either to our office. If you send an e-mail to us and it is not acknowledged within one business day (not counting weekends, holidays, or noticed vacations), you should assume that we have NOT received the e-mail and notify us immediately by calling our office at 214-755-6119. By signing below, you agree that we may use e-mail to communicate with you regarding practical matters – such as billing and scheduling – and **you agree to notify us independently if you send an e-mail and it is not acknowledged by the next business day.**

Please check one of the below options:

- ☐ I do not authorize e-mail communication with Therapy Dallas.
- ☐ I have read and understand the above information, and authorize e-mail communications with Therapy Dallas at the below e-mail address(es):

E-mail: _____ Name: _____

E-mail: _____ Name: _____

I understand this authorization is valid until (indefinite if left blank) _____ , that I may, via written request, withdraw my authorization at any time, and that I have a right to receive a copy of this authorization form.

_____
Patient's Name (Please Print)

_____ _____
Signature of Patient or Parent/Guardian Date