5960 Fairview Road, Suite 300
Charlotte, NC 28210
Tel: 704-441-8715
www.autism-180.com
info@autism-180.com

Permission for Electronic Transmission (Internet and Text) of Information

Electronic transmission means sending information via a device connected to the internet, phone, or cellular service; such as a desktop laptop, tablet, or cell phone utilizing an email, text, or other software, app, or platform. By signing this release, you authorize the staff of Autism180 to electronically transmit information; which may, intentionally or unintentionally, include protected health information and other data related to and about the following individual:

……

Information transmitted will be specific and limited to the intended purpose of the necessary exchange and will be consistent with the need to maintain, improve, or ensure continuity of care. Consistent with Confidentiality and HIPAA rules, information will be shared on a “need to know” basis. Every attempt will be made to minimize the identification of PHI or other sensitive information. Your signature verifies that you understand the risk of sharing information in this manner (see below for identified risks). Risks include an unauthorized party potentially intercepting the information and the information accidentally being sent to or received by an unintended recipient. Additionally, transmission over the internet is not guaranteed delivery. Further, once the electronic transmission is completed by Autism180, Autism180 is not responsible for its subsequent use or re-transmission.

I authorize Autism180 staff to communicate via email or text with the following persons:

1. Individual and/or Individual’s Guardian
2. Autism180 Billing Specialist
3. BCBA
4. ……
5. ……
6. ……
7. ……
8. ……
9. ……

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I give permission for the use of un-encrypted email to be used to exchange information.

☐ Yes

☐ No

This release does NOT give permission to utilize social media and/or platforms other than texting or email exchange.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain support and services from Autism180.

I understand that I may withdraw my authorization at any time. I understand also that such withdrawal of my authorization may not be effective to prevent disclosure of information previously authorized or to stop previous action that has been taken in reliance on this authorization.

My signature means that I have read this form and/or have had it read to me and explained in language I can understand. I know what information will be disclosed, and in what manner, and give my voluntary consent to its release.

My signature means that, if I am not signing for myself, I have the legal authority to sign for the identified individual. My signature confirms that I am the legal representative/guardian for the identified individual.

Individual/Guardian/Legal Representative Signature: