Brightwater
Formerly HDC
HEALTH

1401 East 1st Street, Duluth, MN 55805
AUTHORIZATION FOR COMMUNICATION VIA TEXTING

CLIENT NAME:

_____

Last First Middle Birth date

I hereby authorize and request that the staff of Brightwater Health to communicate with me through texting. I agree to the limitations as outlined below. I understand that:

- **Texting should NOT be used for crisis situations. In the event of a crisis, I should call the crisis line at (800) 634-8775 for MN or (715) 395-2259 for WI or dial 911 for an emergency.**
- **The purpose of texting to provide an alternate means of communication and will only be used when agreed upon between me and Brightwater Health staff member(s) by completion of this authorization.**
- **Texting is not a confidential, secure method of communication.**
- **If phone is lost, misplaced, or accessed by others, information could possibly be discovered by an unauthorized individual.**
- **Texting cannot be used by the provider for communicating confidential client/treatment information (for example, diagnosis or medication information)**
- **Text communication is not always transmitted in a timely manner and may not be received by staff immediately when sent.**
- **I may not receive a timely response to texts from my provider. Inquiries will be responded to during normal business hours as the provider has time.**
- **Texting is meant to be used when other methods of communication are not feasible.**
- **Brightwater Health will not condition treatment on the completion of this authorization.**

REVOCATION AND EXPIRATION OF CONSENT:
This consent will stay in effect unless revoked by the client. I understand that I may revoke this consent to at any time by written notice to the HIS department at Brightwater Health. A photocopy of this authorization may be treated in the same manner as the original. However, Brightwater Health reserves the right to require an original consent. I understand that Brightwater Health will not condition treatment on the completion of this authorization.

_____ _____

Client Signature Signature **of Parent/Guardian**

_____ _____

Date **Relationship to Client**

_____ _____

Witness **Reason acting on client's behalf**

IF CLIENT IS UNABLE TO SIGN, THE PERSON SIGNING THE AUTHORIZATION WILL BE REQUIRED TO SHOW PROOF OF GUARDIANSHIP, OR OTHER AUTHORITY AND RELATIONSHIP TO CLIENT ALLOWING HIM/HER TO AUTHORIZE THE RELEASE OF INFORMATION.

THIS FORM WILL BE ACCEPTED ONLY IF ALL ITEMS HAVE BEEN COMPLETED

1/2015, 10/2025

Client Name:_____

MR #_____