

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____
(name of client)

AUTHORIZE: _____
(name of clinician)

(street address)

TO TRANSMIT PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT BY THE FOLLOWING NON-SECURE MEDIA:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment

TERMINATION

This authorization will terminate _____ days after the date listed below.

OR

This authorization will terminate when the following event occurs:

_____.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

(Signature of client)

Date