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

I, ________________________________ AUTHORIZE: ____________________________

(name of client) (name of clinician)

TO TRANSMIT TO ME BY NON-SECURE MEDIA (Ex: emails and/or texting) THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- ☐ Information related to the scheduling of meetings or other appointments
- ☐ Information related to billing and payment (but not to include any financial or claims-related identifiers including, but not limited to, credit card numbers, insurance plan numbers, diagnosis codes, or procedure codes.)
- ☐ Anything else I deem appropriate or wish to communicate with my therapist

TERMINATION

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

OR

O 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. I understand that **Engaging Therapies LLC** makes available to me means of communication that are designed to be secure and to maintain confidentiality, and I still choose to request and authorize the above-named non-secure means.

________________________________ _________________

Signature of client Date

________________________________ _________________

Signature of Parent/Guardian Date

________________________________ _________________

Signature of Therapist Date