



Nonsecure Transmission of Protected Health Information

I, _____, AUTHORIZE _____
(name of client) (name of clinician)

TO TRANSMIT THE FOLLOWING
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
- Completed forms, including forms that may contain sensitive, confidential information
- Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
- My health record, in part or in whole, or summaries of material from my health record
- Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:

- Unsecured email.
- SMS text message (i.e. traditional text messaging) or other type of "text message."
- Other media. Describe: _____.

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