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

I, ______________________________ AUTHORIZE: ____________________

(name of client) (name of clinician)

______________________________ ____________________

(date of birth) (street address)

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

- Information related to the scheduling of 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.)
- Other

TERMINATION

____This authorization will terminate at the completion of treatment.

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

______________________________ ____________________

(Signature of Guardian) Date

______________________________ ____________________

(Signature of witness) Date