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

I, AUTHORIZE:

 (name of client) (name of clinician)

 (street address)

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

1. Information related to the scheduling of meetings or other appointments
2. 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.)
3. Forms

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.

(Signature of parent or guardian) Date

(Signature of client) Date