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

I, ____________________________ AUTHORIZE: Debbie Bensching
(name of client) (name of clinician)

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

O Information related to the scheduling of meetings or other appointments

O Information related to billing and payment

O Completed forms, including forms that may contain sensitive, confidential information

O Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment

O Other information. Describe: ____

BY THE FOLLOWING NON-SECURE MEDIA:

O Normal, unsecured, email.

O SMS text message (i.e. traditional text messaging) or other type of "text message."

O Other media. Describe:____

PLEASE USE THE FOLLOWING:

O Email(s): ____

O Phone for text messages: __________________________________

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 and of communications policy regarding communications. 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.