Christy Anderson Jacob, Ph.D

Licensed Psychologist

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

I, ______________________________________ **AUTHORIZE:** ________________________________

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

BY THE FOLLOWING NON-SECURE MEDIA:

O Unsecured email.

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

TERMINATION:

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

O Upon client’s written request.

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 my therapist makes available the following means of communication that are designed to be secure, and I still choose to authorize to the above-named non-secure means:

- Encrypted email
- Secure texting

____ ____________________

Signature of client Date

3820 Cleveland Ave N, Suite 400
Arden Hill, MN 55112

651-389-4406
christy@cmajinc.com

____________________________________ ____________________

Signature of witness if minor Date