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

I, _____ AUTHORIZE Dawn A Dillon, M.Ed, LPC, NCC, 3108 W. 6th Street, Suite 207, Fort Worth, TX 76107, 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 My health record, in part or in whole, or summaries of material from my health record

O Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:

O Unsecured email.

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

O Other media. Describe:

_____

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.

_____ _____

Client Signature Date

_____

Printed Name