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

I, ________________________________ AUTHORIZE Dawn A Dillon, M.Ed, LPC, NCC, CEDS, to TRANSMIT THE FOLLOWING protected health information related to my health records and healthcare information (check all that apply):

O Information related to the scheduling of meetings or other appointments
O Information related to billing and payment
O Other information. Describe: ____

BY THE FOLLOWING NON-SECURE MEDIA (check all that apply):
O Unsecured email
O SMS text message (i.e. traditional text messaging) or other type of "text message."
O Thera-link, video-counseling platform

TERMINATION (choose one)
O This authorization will terminate in _________ days after the date listed below.

O This authorization will terminate when counseling is terminated/completed.

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