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

I, _____ AUTHORIZE: ___Jenny Boyce, LPC, ATR____
(name of client)
_____of Jenny Boyce Counseling, 8514 SE Stark St., Portland, OR, 97216_____

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

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 therapy ends.

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 client) Date