

**CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION BY
UNSECURE TRANSMISSIONS**

This consent form is for the communication of Protected Health Information (“PHI”) that NAME may transmit without the written authorization of the client as described in the Uses and Disclosure section of NAME’s Notice of Privacy Policies.

I, _____, hereby consent and authorize Shari Y. Johansson to communicate my PHI through the following non-secure transmissions (please initial all your choices):

- _____ Cellular/Mobile Phone this includes text messaging
(Please Insert Cell Phone Number: _____)
- _____ Unsecured Email
(Client’s Email: _____ Send Receive
Therapist’s Email: _____ Send Receive)
Please Circle One: Work Personal
- _____ Appointment/Scheduling Reminder System
- _____ Other Media:
(Please describe: _____)
- _____ I do not wish to have my protected health information transmitted electronically

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, I cannot guarantee that those communications will remain confidential. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I, _____, understand that Shari Y. Johansson may use and disclose the following PHI without my written authorization. However, I consent to Shari Y. Johansson transmitting the following PHI by the above selected electronic communications (please initial all your choices):

- _____ Information related to scheduling/appointments
- _____ Information related to billing and payments
- _____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
- _____ Information related to NAME’s operations
- _____ Other Information; Please Describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

Signature of Client/Parent/Legal Guardian

DATE