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

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I, _____ authorize: Brian Sorrells,
(name of client) 3575 Donald Street, # 650
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to transmit protected health information related to my health records and health care treatment by the following non-secure media:

- **Information related to the scheduling of meetings or other appointments**
- **Information related to billing and payment**
- **Completed forms, including forms that may contain sensitive, confidential information**
- **Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment**
- **My health record, in part or in whole, or summaries of material from my health record**
- **Other information. Describe: _____**

By the following Non-secure media:

- **Unsecured email**
- **SMS text message (i.e. traditional text messaging) or other type of texting.**
- **Other media. Describe: _____**

<u>TERMINATION:</u>
_____ This authorization will terminate _____ days after the date listed below
OR
_____ This authorization will terminate when the following event occurs:
CURRENT COURSE OF TREATMENT 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