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

I, _____ AUTHORIZE: _____
(name of client) (name of counselor)

TO TRANSMIT TO ME BY NON-SECURE MEDIA THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- ☐ Information related to the scheduling of meetings or other appointments
- ☐ Information and resources to support my therapy

TERMINATION (choose one)

☐ This authorization will terminate ____ days after the date listed below.

OR

☐ This authorization will terminate when the following event occurs: When the EAP benefit year renews.

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.

OPTIONAL, BUT STRONGLY RECOMMENDED:
I understand that my clinician / counselor makes available to me the following means of communication that are designed to be secure and to maintain confidentiality, and I still choose to request and authorize the above-named non-secure means:

- ☐ *Phone calls only*
- ☐ *Secure texting app*

_____ _____
(Signature of client) Date