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

Complete this form after reading the "Email & Text Risks" document, only if you choose to receive email and/or texts.

I, ___________________________________ AUTHORIZE: Dr. Sheila Addison
(name of client) 1900 Addison St. Suite 200
Berkeley, CA 94704

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

_____ Information related to the scheduling of meetings or other appointments

_____ Information related to billing and payment

_____ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment (check here if email only: ☐)

_____ My health record, in part or in whole, or summaries of material from my health record (check here if email only: ☐)

_____ Other information. Describe: ____

BY THE FOLLOWING NON-SECURE MEDIA:

_____ Unsecured email.

_____ SMS text message (i.e. traditional text messaging) or other type of "text message."

_____ Other media. Describe: ____.

TERMINATION

_____ This authorization will terminate _____ days after the date listed below.

OR

_____ This authorization will terminate when I revoke my consent.

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.

I understand that Dr. Sheila Addison uses the following secure service(s) for storing and transmitting receipts, superbills, and formal treatment summaries:

- Sookasa – encrypted storage within Dropbox
- Espionage – encrypted storage for Apple OS devices

____ _____________________

Signature Date