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

I, ______________________________ AUTHORIZE: Holly Shumway MA NCC LPC ____
15100 SW Boones Ferry Rd. Suite 850 AB
Lake Oswego, OR 97035

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

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 the following event occurs: ________________________________.

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.

SECURITY NOTICE

I understand that Holly Shumway makes available the following means of communication that are designed to be secure, and I still choose to authorize to the above-named non-secure means:

- Encrypted email (Patient Ally) https://www.patientally.com/Main
- Secure texting app (HIPAA Chat) http://www.hipaachat.com/

______________________________________ ____________________
(Signature of client) Date