REQUEST FOR THE TRANSMISSION OF PROTECTED HEALTH INFORMATION BY AN NON-SECURE METHOD OF TRASPORT.

I, _____

AUTHORIZE:
Lynda Phillips
Phillips Mental Health Counseling PC
61-18 190th Street Suite 236
Fresh Meadows, NY 11365

I authorize Lynda Phillips to send my health records in a non-secure form of transport

- ☐ Information related to the scheduling of meetings or other appointments
- ☐ Information related to billing and payment (but not to include any financial or claims-related identifiers including, but not limited to, credit card numbers, insurance plan numbers, diagnosis codes, or procedure codes.)

The termination date will end on the date specified below.
Authorization to send the documents will terminate ten days after the date listed below. Or if other variables are involved the authorization will terminate when as required by the office to protect the record.

I am the client of Lynda Phillips, and I have been informed of the potential risks involved in a breach of privacy/confidentiality if I have my personal health records transmitted in a non-secure way. I do understand that I am not required to sign this document to receive treatment. I sign this agreement with the full understanding that I may terminate the agreement at any time.

I understand that Lynda Phillips has offered to send my documents through encrypted e-mail and I would still like my documents sent in the above-listed non-secure format.

_____

(Signature of client) Print name Date