OPTIONAL FORM

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

I, ________________________________ (Name of client)

AUTHORIZE: Sarah H. Kramer, Ph.D.
6401 Eldorado Pkwy, Suite 231
McKinney, TX 75070
Business cell: 469-708-2997

TO EXCHANGE WITH ME BY NON-SECURE MEDIA (such as SMS or other standard text programs) THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- Information related to the scheduling of, or lateness for, meetings or other appointments
- A link to Dr. Kramer's website for access to directions, new patient paperwork etc.
- A statement announcing my arrival at Dr. Kramer's office (using my first name and last initial only, please)

TERMINATION

O This authorization will terminate _______ days after the date of signing.

OR

O This authorization will terminate when the following event occurs: discharge or no visits for 3 months or longer

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 also understand that Dr. Sarah Kramer makes available to me the following means of communication that are designed to be secure and to maintain confidentiality, and I still choose to authorize the above-named non-secure means:

--Encrypted email via TherapyAppointment.com
--Secure voicemail at 469-625-1162

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Signature of client (or parent, if client under age 18) Date

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Print Name of Client