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CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION BY NON-SECURE TRANSMISSIONS

This consent for is for the communication of Protected HEALTH INFORMATION that Footsteps Counseling may transmit without the written authorization of the client as described in the Uses and Disclosure section of Footsteps Counseling's Notice of Privacy Policies and Practices and Compliance with HIPAA regarding confidentiality of client record and dissemination of information.

I, ______________________________, hereby consent and authorize Footsteps Counseling to communicate my protected health information through the following non-secure transmissions **(Please initial you choices)**

________ Cellular/Mobile Phone (this includes SMS) as listed on Footsteps Counseling New Client information Form.

________ Unsecured Email as Listed on Footsteps Counseling New Client information form **(this will allow Footsteps Counseling to send you appointment reminders and/or homework assignments).**

________ I do not wish to have my protected health information transmitted electronically. ***Please be aware that checking this box will prohibit us from sending you appointment reminders, homework assignments, or communicating with you by phone.**

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, Footsteps Counseling cannot guarantee that those communications will remain confidential. Even though Footsteps Counseling may utilize state of the art encryption methods, firewalls and backup systems to help secure communications, there is a risk that our electronic or telephone communications may be compromised, unsecure, and/or accessed by a unintended third party.

I, __________________________, understand that Footsteps Counseling may use and disclose the following protected health information without my written authorization. However, I consent to Footsteps Counseling transmitting the following protected health information by the above selected electronic communications. **(please Initial your choices)**

________ Information related to scheduling (e.g. appointment reminders)
________ Information related to billing and payments
________ Information related to your mental health treatment **(may contain personal material forms, suggested articles, homework, etc.)**
________ Information related to Footsteps Counseling Operations.
________ Other information, Please Describe: ______________________.

______________________________ ____________________

Client Signature (or Parent/Guardian) Date

______________________________ ____________________

Client Signature (or Parent/Guardian) Date