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

I, _____ AUTHORIZE: Dr. Lisa Schwellinger
(name of client)

P.O. Box 540592

Greenacres, FL 33454

TO TRANSMIT TO ME BY NON-SECURE MEDIA THE FOLLOWING TYPES OF 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 (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.)

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.

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

- ☐ *Hushmail (e.g. encrypted email)*

_____ _____
(Signature of client) Date