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

I, ___________________ authorize **Jill W. Hess, M.S., CCC-SLP (Connect the Tots)** to transmit to me by non-secure media the following types of protected health information related to me or my child's health records and healthcare treatment:

- Information related to the scheduling of meetings or 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).

I have been informed of the risks, including but not limited to confidentiality in treatment, of transmitting mine or my child's 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; otherwise, this authorization will terminate when _________________ is discharged from therapy services.

Signature__________________________________ Date_______________________