

Andrea Williams MSW, LCSW

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION VIA UNSECURE TRANSMISSIONS

This consent form is for the communication of Protect Health Information (“PHI”) that Apollo Counseling, may transmit without the written authorization of the client as described in the Uses and Disclosure section of Apollo Counseling’s Notice of Privacy Policies.

I, _____, hereby consent and authorize Apollo Counseling, to communicate my PHI through the following unsecure transmissions (please initial all your choices):

_____ Cellular/Mobile Phone: this includes text messaging
(Please Insert Cell Phone Number/s:
_____)

_____ Unsecured Email
Client’s _____ Email:
_____ Send Receive

Therapist’s Email: andrea.elainewilliamss@gmail.com Send Receive
Please Circle One: Work Personal

_____ Appointment/Scheduling Reminder System (Simple Practice) (text or email or both)

_____ Other Media:
(Please describe: _____)

_____ I do not wish to have my protected health information transmitted electronically

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, I understand that Apollo Counseling, cannot guarantee that those communications will remain confidential. Even though Apollo Counseling may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I, _____, understand that Apollo Counseling, may use and disclose the following PHI without my written authorization. However, I consent to Apollo Counseling , transmitting the following PHI by the above selected electronic communications (please initial all your choices):

- _____ Information related to scheduling/appointments
- _____ Information related to billing and payments
- _____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
- _____ Information related to Apollo Counseling’s operations

_____ Other Information; Please Describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

Signature of Client

DATE

Signature of Parent/Legal Guardian

DATE

Signature of Parent/Legal Guardian

DATE

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DATE