

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY EMAIL AND
SMS TEXT (NON-SECURE MEANS)

I, _____ authorize: Anne Cooper, Psy.D.
(name of client)

851 Fremont Ave., Ste 108, Los Altos, CA

To transmit to me email and SMS text that are non-secure media (my Google account and cell phone), the following types of Protected Health Information (PHI) 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
- Information related to Dr. Cooper's replies to emails or texts that are initiated by me, the client
- Blank office policy forms

Termination (please check one)

This authorization will terminate _____ days after the date listed below.

OR

This authorization will terminate when the following event occurs: one year after termination of therapy.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my PHI 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.

(Signature of client)

Date