

**Kari Berquist, Ph.D., BCBA-D**

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**CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY  
NON-SECURE MEANS**

Client/Child's Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_

I, \_\_\_\_\_ (child's legal guardian), hereby AUTHORIZE: **Dr. Kari Berquist** TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY CHILD'S HEALTH RECORDS AND HEALTH CARE TREATMENT:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Completed forms, including forms that may contain sensitive, confidential information
- Information of a therapeutic or clinical nature, including discussion of personal material relevant to my child's health records
- My child's health record, in part or in whole, or summaries of material from my child's health record
- Other information. Describe: \_\_\_\_\_

**BY THE FOLLOWING NON-SECURE MEDIA:**

- Unsecured email.
- SMS text message (i.e. traditional text messaging) or other type of "text message."
- Other media. Describe: \_\_\_\_\_.

**TERMINATION**

- This authorization will terminate \_\_\_\_\_ days after the date listed below.
- 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. Kari Berquist makes available the following means of communication that are designed to be secure, and I still choose to authorize to the above-named non-secure means:

Method 1: Virtru and Google Apps for Work Encrypted Email

Method 2: Doxy.me and Google Meet

Method 3: Spruce Health

\_\_\_\_\_  
Printed name of legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of legal guardian

\_\_\_\_\_  
Relationship to client