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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:

O Information related to the scheduling of meetings or other appointments

O Information related to billing and payment

O Completed forms, including forms that may contain sensitive, confidential information

O Information of a therapeutic or clinical nature, including discussion of personal material relevant to my child's health records

O My child's health record, in part or in whole, or summaries of material from my child's health record

O Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:

O Unsecured email.

O SMS text message (i.e. traditional text messaging) or other type of "text message."

O Other media. Describe:_____.

TERMINATION

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

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. 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: Google Meet

Method 3: Spruce Health

_____ _____

Printed name of legal guardian Date

_____ _____

Signature of legal guardian Relationship to client