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

I, _____ AUTHORIZE: **Polaris Counseling**
(name of client)

800 W. 5th Avenue, Suite 205I
Naperville, IL 60563

TO TRANSMIT TO ME BY NON-SECURE MEDIA THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT (check all that apply):

- o Information related to the scheduling of meetings or other appointments
- o 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.)
- o Information related to treatment (included, but not limited to, diagnosis, assessment, treatment plan, case notes and dates of service)

TERMINATION

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

OR

- 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 _____ makes available to me the following means of communication listed below that are designed to be secure and to maintain confidentiality, and I still choose to request and authorize the above-named non-secure means:

- TheraNest Secure Messaging via Client Portal
- Encrypted email (contact@polariscounseling.com)
- Fax (630-753-0942). NOTE: ONLY when you have confirmed office staff are in the office and able to receive fax upon transmission
- Phone (630-779-0751)

_____ _____
Signature of client Date