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

I, _____
(name of client)

AUTHORIZE: Jolene Stokesberry
120 Pear St. NE., Olympia, WA 98506

It may become useful during the course of treatment to communicate by email or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Jolene Stokesberry there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with Jolene Stokesberry
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with Jolene Stokesberry about ways to keep your communications safe and confidential.

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- Information related to the scheduling of meetings or other appointments
- 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 treatment
- My health record, in part or in whole, or summaries of material from my health record
- Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:

- Unsecured email.

TERMINATION

- This authorization will terminate 365 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.

(Signature of client)

Date