Jennifer Shtrum M.A., LMFT #46038

AUTHORIZATION FOR ELECTRONIC TRANSMISSION OF PROTECTED HEALTH INFORMATION

Name:_____Date:_____

Date of Birth:_____

Protected heath information (PHI) is any information in the medical record or designated record set that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment or billing. You may authorize me to release your PHI to answering devices, faxes or electronic mail. To ensure your privacy, I will not leave messages containing PHI on answering devices without your permission.

I authorize Jennifer Shtrum, LMFT to contact me via the following:

___ fax number:_____

___ telephone answering device: _____

___ email address:_____

___ mobile phone/text message:_____

Signature_____Date: _____

This authorization shall remain in effect until you are notified by me in writing of any changes.