Client Name: _____ DOB:_____

REQUEST FOR COMMUNICATION BY NON-SECURE MEANS OF TRANSMISSION

SECTION 1: AUTHORIZATION REQUEST/DENIAL

I, _____ Client Parent/Guardian

Hereby AUTHORIZE DO NOT AUTHORIZE (Please proceed to section 3)

Bethany Johnson, LCSW and Business Associates of B Johnson LLC
Located at: 606 E Main Street, STE 2, Madison, IN 47250

SECTION 1B: TO COMMUNICATE IN THE FOLLOWING IDENTIFIED MEANS OF NON-SECURE TRANSMISSION:

_____ p: (234) 444-5055 _____e: bethany.johnsonlcsw@outlook.com
_____ f:(812) 265-5028 _____ Squarespace POS/Acuity Scheduling

SECTION 2: CLIENT PREFERENCES

SECTION 2a: TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY/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 such as Square Invoicing/POS system (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.)
- SMS Correspondence between client/guardian and therapist initiated by the client/guardian from the contact number identified below for such communication.
- Email correspondence between client/guardian and therapist initiated by the client/guardian from the email address identified below as preferred method of contact.
- Voicemail on identified contact phone numbers below
- Online Scheduling through Squarespace/Acuity Scheduling and reminder/notices about appointment

SECTION 2b: NON-SECURED MEANS OF TRANSMISSION AND COMMUNICATION

_____ TEXT/VOICEMAIL: _____
_____ EMAIL: _____
_____ FAX: _____
_____ OTHER:_____

SECTION 2c: CONDITIONS OF TERMINATION OF AUTHORIZATION

_____This authorization will terminate _____ days after the date signed below.
_____ This authorization will terminate upon request of client/guardian or at the discretion of therapist

SECTION 3: ACKNOWLEDGEMENT

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by secure and unsecured means.

I understand and accept that by signing this I am responsible for security or privacy of PHI upon receipt of transmission to above identified means of transmission, regardless of being secure or unsecured.

I understand the limitations of security of the information sent by me to Bethany Johnson, LCSW and business associates when authorizing the use of non-secured means of transmission such as text or unencrypted email.

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 *Bethany Johnson, LCSW and B Johnson LLC* makes available to me the following means of communication that are designed to be secure and to maintain confidentiality, and I still choose to request and authorize the above-named non-secure means at the discretion of Bethany Johnson, LCSW and Business Associates:

- *Encrypted Email*
- *Paper request*
- *FAX*

_____ _____ _____
(Signature of client) Date Authority to Release

Client Name: _____ DOB:_____

TERMINATE AND/OR UPDATE NON-SECURE COMMUNICATION AUTHORIZATION

SECTION 1: REQUEST TYPE

I, _____, CLIENT PARENT/GUARDIAN

REQUEST THAT PREVIOUSLY ESTABLISHED AUTHORIZATION FOR UNSECURED METHODS OF COMMUNICATION OF PATIENT HEALTH INFORMATION (PHI) TO BE:

UPDATED (proceed to section 2) TERMINATED (proceed to section 3)

SECTION 2. UPDATED TERMS FOR NON-SECURE COMMUNICATION AUTHORIZATION

I, THE ABOVE SIGNED, AUTHORIZE THE FOLLOWING MEANS OF TRANSMISSION/COMMUNICATION

TEXT EMAIL FAX

ALTERNATIVE/UPDATED NON-SECURE TRANSMISSIONS CAN BE MADE THROUGH THE FOLLOWING:

TEXT: _____

EMAIL: _____

FAX: _____

ADDITIONALLY I REQUEST THAT ALL PREVIOUSLY AUTHORIZED METHODS OF COMMUNICATION:

IN ADDITION TO ABOVE IDENTIFIED CHANGES

CEASE ALL PREVIOUSLY AUTHORIZED STANDARDS

Please continue below to Section 4

SECTION 3.: TERMINATE NON-SECURE COMMUNICATION AUTHORIZATION

I am requesting that all non-secure communication cease from Bethany Johnson, LCSW/B Johnson LLC and Business Associates from the date undersigned.

I understand that although I can continue to send unsecured text messages/email, that Bethany Johnson, LCSW and associates will NOT respond to said messages/ emails without encryption.

I also understand that it my responsibility to opt-out of all confirmation and reminder notification emails/ text messages from 3rd party business associates such as Squarespace (POS)/Acuity Scheduling separately from this Authorization termination.

I accept all previous received communications from Bethany Johnson LCSW/ B Johnson, LLC via unsecured methods are subject to my own privacy/personal security measures.

Please continue below to section 4

SECTION 4: AUTHORIZATION

I _____, client parent/guardian, am requesting to:

update of preferences or termination of, previous authorization for NON-SECURED means of communication of Patient Health Information for myself and/or child henceforth of the date undersigned. I acknowledge that all risk associated with non-secure means of transmission were discussed at time of initial authorization, and reviewed with me at the undersigned date in which this requested was signed. I understand that is is my right to request termination at any time and it is not a requirement to sign this agreement to receive therapeutic services by Bethany Johnson, LCSW.

_____	_____	_____
Signature	Printed Name/Role	Date
_____	_____	_____
Witness Signature	Witness Printed Name/ Title	Date