



WELL MIND THERAPY
Transforming Lives Through Compassionate
Counseling & Care

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Consent to Transmit Information via Non-Secure Means

_____ (Initials) I consent to allow Wajeeha Khan, LMFT 97158 to use email and mobile phone text messaging to transmit to communicate with me regarding services, including personally identifiable information. I understand that these means of communication are not always secure.

- Service related check-ins
- Information related to the scheduling of meetings or other appointments
 - Acknowledgment of emails and phone calls received
- Other: _____

OR

_____ (Initials) I do not consent to allow Wajeeha Khan, LMFT 97158 to use email and mobile phone text messaging to transmit to communicate with me regarding services, including personally identifiable communication. I understand that these means of communication are not always secure. I understand that alternate methods of communication and transmission will be used.

I have been informed of the risks, including but not limited to my confidentiality in services, of transmitting my protected health information by unsecured means. I understand that I may change my decision at any time.

Patient's Full Name

Patient's Signature

Date