Karyn L. Aho, Ph. D.

492 East 13th Ave Suite 102 • Eugene, OR 97401 • Office: 541-342-5558 • Fax: 541-342-5565

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

I, ____ **AUTHORIZE: Karyn L. Aho, Ph.D.**

Client Full Name

TO TRANSMIT TO ME BY NON-SECURE MEDIA THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

1. Information related to the scheduling of meetings and appointments
2. 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.)

My Termination Rights & Responsibilities:

- This authorization will terminate _______ days after the date listed below.
- This authorization can terminate at any time.
- I understand that termination requires written notification to my provider Karyn L. Aho, Ph.D.
- 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 understand that Karyn L. Aho Ph.D. 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.

- **Phone:** office landline 541-342-5558.
  - You may leave messages on the confidential voicemail
- **Text message:** smart phone 541-543-9300
  - *Secure/encrypted -* via **Signal** free app that you can download to your computer or smartphone.
  - *Non secure* – Normal text message
- **Email:**
  - *Secure/encrypted hushmail* email address: drkaho@karynaho.com
  - *Non secure* general email address: aho.karyn@gmail.com

____ ________________________

(Signature of client) Date