ROBLEY K. YEE, Ph.D., LICSW

Licensed Independent Clinical Social Worker
Individual and Relational Psychotherapy

Robley K. Yee, Ph.D., LICSW

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Consent for Communications by Non-HIPAA Compliant Methods

Client Name:_____

It may become useful during the course of treatment to communicate by email, text, or other methods of communication. Be informed that these methods, in their typical form are not secure and confidential methods of communication. If you choose these methods, instead of the HIPAA compliant methods available, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. Third party includes, but is not limited to:

- People in your home or other environments who may be able to 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 our office
- 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 reconsider the using nonsecure methods of communicating with our office.

I, _____, authorize Robley K Yee, PhD and his office:

To transmit the following protected health information related to my health records and health care treatment (initial all that apply):

_____ • Information related to the scheduling of meetings or other appointments
_____ • Information related to billing and payment
_____ • 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 (initial all that apply):

_____ • Unsecured email
_____ • SMS text message (traditional text messaging) or other type of "text message.:
_____ • Other media. Describe: _____

Termination (please select one of the following):

- This authorization will terminate _____ days after the date listed below.
- 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 require to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

I understand that Robley K. Yee, PhD and his office have offered communication methods that are HIPAA compliant (secure) and I still choose to authorize the above named non-secure means of communication.

_____ _____

(Signature of Client) (Date)