CONNECT PSYCHOLOGICAL SERVICES, LLC

1580 South Milwaukee, Ave. Suite 407 Libertyville, Il 60048
847) 502-5218

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

I, _____ AUTHORIZE: Dr. Karen O'Keeffe
(name of client) 1580 S. Milwaukee Ave. #407
Libertyville, Il 60048

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

- ☐ Information related to the scheduling of meetings or other appointments.
- ☐ Information related to billing and payment.
- ☐ Information related to my treatment and health history.

TERMINATION
[] This authorization will terminate _____ days after the date listed below.
OR
[] This authorization will terminate when the following event occurs: _____.

Confidentiality Warning:
Please know that despite the use of firewalls and security programs, there is no guarantee of privacy in emails or anywhere else on the internet. Confidentiality is limited.

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 Dr. Karen O'Keeffe cannot guarantee my privacy from outside sources. 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 *Dr. Karen O'Keeffe* makes available to me encrypted email, encrypted text messaging, and encrypted video conferencing that are designed to increase security and confidentiality, but I still choose to request and authorize non-secure means:

_____ _____
(Signature of client) Date

_____ _____
(Signature of therapist) Date

Updated 10/22