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
(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-- end of therapy

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. Email communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Email is vulnerable to such unauthorized access since servers have unlimited and direct access to all emails that go through them. If you use an email address connected to your workplace or other people, the risk to compromising your privacy and confidentiality increases. It is important that you be aware that emails are part of your medical record. Un-encrypted emails are even more vulnerable to unauthorized access. Please notify Dr. Karen O'Keeffe if you decide to avoid or limit in any way the use of email. **Please do not use email for emergencies**. Phone messages and emails are checked frequently but may not be checked daily, particularly if I am out of town, it is outside of business hours, the weekend, or a holiday. My preferred mode of communication is a phone call or voice mail.

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 to receive treatment. 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