Philip Harms/Deep Roots Therapy PC is working as an independent contractor with
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Consent For Communication of Protected Health Information by Unsecure Transmissions

This consent form is for the communication of Protect Health Information ("PHI") that DEEP ROOTS THERAPY PC may transmit without the written authorization of the client as described in the Uses and Disclosure section of DEEP ROOTS THERAPY PC's Notice of Privacy Policies.

I, _____, hereby consent and authorize DEEP ROOTS THERAPY PC to communicate my PHI through the following unsecure transmissions (please initial all your choices):

_____ Cellular/Mobile Phone this includes text messaging
(Please Insert Cell Phone Number: _____)
_____ Unsecured Email
(Client's Email: _____ □ Send □ Receive
Therapist's Email: _____ □ Send □ Receive)
Please Circle One: Work Personal
_____ Appointment/Scheduling Reminder System (TherapyNote.com)
_____ Other Media:
(Please describe: _____)
_____ I do not wish to have my protected health information transmitted electronically

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, I understand that confidentiality extends to those communications. However, I understand that DEEP ROOTS THERAPY PC cannot guarantee that those communications will remain confidential. Even though DEEP ROOTS THERAPY PC may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I, _____, understand that DEEP ROOTS THERAPY PC may use and disclose the following PHI without my written authorization. However, I consent to DEEP ROOTS THERAPY PC transmitting the following PHI by the above selected electronic communications (please initial all your choices):

_____ Information related to scheduling/appointments
_____ Information related to billing and payments
_____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
_____ Information related to DEEP ROOTS THERAPY PC's operations

_____ Other Information; Please Describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

_____ _____

Client#1/Legal Representative Signature **Date**

_____ _____

Client #2/Legal Representative Signature (if necessary) **Date**