

Kimberly Pearson, M.D.
68 Leonard Street
Belmont, MA 02478
(617) 383-4453

**CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION
BY NON-SECURE MEANS**

I, _____ AUTHORIZE: Kimberly Pearson, M.D.
(name of patient) 68 Leonard Street
Belmont, MA 02478
(617) 383-4453
kim@kimberlypearsonmd.com

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- Information related to the scheduling of 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:

- Unsecured email
- SMS text message (i.e. traditional text messaging) or other type of “text message”
- Phone calls that take place on VOIP services
- Other media. Describe: _____.

TERMINATION

This authorization will terminate _____ days after the date listed below.

OR

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 required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

(Signature of patient)

Date