Kimberly Pearson, M.D.
1330 Beacon Street
Suite 324
Brookline, Massachusetts 02445

(p) 617 383 4453
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CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, ___________________________ AUTHORIZE: Kimberly Pearson, M.D.
name of patient
1330 Beacon Street
Suite 324
Brookline, Massachusetts 02445
(617) 383-4453
kim@kimberlypearsonmd.com

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

O Information related to the scheduling of appointments
O Information related to billing and payment
O Completed forms, including forms that may contain sensitive, confidential information
O Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
O My health record, in part or in whole, or summaries of material from my health record
O Other information. Describe: ____

BY THE FOLLOWING NON-SECURE MEDIA:
O Unsecured email
O SMS text message (i.e. traditional text messaging) or other type of “text message”
O Phone calls that take place on VOIP services
O Other media. Describe: ____.

TERMINATION:
O This authorization will terminate ________days after the date listed below. OR
O 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*