

## Sagewood Counseling

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

I, \_\_\_\_\_ AUTHORIZE: Lisa LeMay  
(name of client) 5798 Blackshire Path  
Inver Grove Heights, MN 55076

**TO TRANSMIT THE FOLLOWING 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, including emailed Square invoices and receipts.
- 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
- 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."
- 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 client)

\_\_\_\_\_  
Date

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