CHADWICK ROYAL, PHD, LPCS
LICENSED PROFESSIONAL COUNSELOR SUPERVISOR

REQUEST FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ , AUTHORIZE Chadwick Royal, PhD, LPCS
(name of client)

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 (but not to include any financial or claims-related identifiers including, but not limited to, credit card numbers, insurance plan numbers, diagnosis codes, or procedure codes.)

Disclosure Regarding Third-Party Access to Communications

Please know that if we use electronic communications methods, such as email, texting, online video, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others.

Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

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

106 S. 4TH STREET
SUITE F
MEBANE, NC 27302

336-684-0697
WWW.CHADWICKROYAL.COM
DR@CHADWICKROYAL.COM