**Sam Poyta Counseling, PLLC**

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**Consent for Transmission of Protected Health Information by Non-Secure Means**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client’s Name) hereby authorize

Samantha Poyta, MSW, LICSW to:

Transmit protected health information related to my health records and health care treatment by the following non-secure media:

Information related to the scheduling of meetings or other appointments.

Information related to billing and payment.

* This authorization shall expire one year from the date signed

OR

* This authorization will terminate when services are terminated

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by non-secure means. I understand that I am not required to sign this agreement in order to participate in services. I also understand that I may terminate this authorization at any time.

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Client Signature Date