New Peaks
NEUROPSYCHOLOGY
777 29th Street, Suite 200, Boulder, CO 80303
Office: 303-200-4780 • Fax: 720-647-3011

Kristin B. Powell, Ph.D., ABPP-CN
Jill Gitten Aloia, Ph.D., ABPP-CN
Zachary W. Sussman, Ph.D.
Emily C. Maxwell, Ph.D.

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

Communication by Non-Secure Methods
It may become useful during the course of treatment to communicate by email or other electronic means of communication. These non-secure methods are not confidential means of communication. If you use these methods to communicate, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to: people in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages, your employer, your school, or other organizational email accounts if you use these types of email addresses to communicate with Dr. Powell, Dr. Aloia, Dr. Sussman, Dr. Maxwell, or Dr. Meyer third parties on the internet such as server administrators and others who monitor internet traffic. Please take a moment to contemplate the risks involved if any of these persons were to access the messages you exchange with Dr. Powell, Dr. Aloia, Dr. Sussman, Dr. Maxwell, or Dr. Meyer.

I understand that Dr. Powell, Dr. Aloia, Dr. Sussman, Dr. Maxwell, and Dr. Meyer make available to me means of communication that are designed to be secure and to maintain confidentiality (office phone and fax, paper copiesof documents), and I still choose to request and authorize the below-named non-secure means:

In addition to communicating using secure methods, I prefer to communicate using the following non-secure methods:

Email ☐ Yes ☐ No

I,____, authorize Dr. Powell, Dr. Aloia, Dr. Sussman, Dr. Maxwell or Dr. Meyer 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.)
- ☐ Information related to my or my child’s ongoing clinical care
- ☐ Communication with other professionals related to my or my child’s ongoing clinical care
- ☐ Neuropsychological Reports

I have been informed of the risks, including but not limited to my confidentiality in treatment, and 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)