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CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION VIA UNSECURE TRANSMISSIONS

This consent form is for the communication of Protect Health Information (“PHI”) that Dee Marcotte, LPC, CSAT, ACS may transmit without the written authorization of the client as described in the Uses and Disclosure section of Dee Marcotte, LPC, CSAT, ACS’s Notice of Privacy Policies.

I, _____, hereby consent and authorize Dee Marcotte, LPC, CSAT, ACS to communicate my PHI through the following unsecure transmissions (please initial all your choices):

- _____ Cellular/Mobile Phone this includes text messaging & voicemails
Please Insert Cell Phone Number: _____
- _____ Unsecured Email
Client’s Email: _____ Send Receive
Please Circle One: Work Personal
- _____ Therapist’s Email: _____ Send Receive
- _____ Other Media: Please describe: _____
- _____ I do not wish to have my protected health information transmitted electronically

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, Dee Marcotte, LPC, CSAT, ACS cannot guarantee that those communications will remain confidential. Even though Dee Marcotte, LPC, CSAT, ACS may utilize state of the art encryption methods, firewalls, and/or back-up systems to help secure our communication, there is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I, _____, consent to Dee Marcotte, LPC, CSAT, ACS **transmitting** the following PHI by the above selected electronic communications (please initial all your choices):

- _____ Information related to scheduling/appointments
- _____ Information related to billing and payments
- _____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
- _____ Information related to Dee Marcotte, LPC, CSAT, ACS’s operations
- _____ Other Information; Please Describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

Signature of Client/Parent/Legal Guardian

DATE