



Faith Halverson-Ramos, MA, LPC, MT-BC
 303-521-2791
faith@soundwellmusictherapy.com
 Create Sound Well-Being Through Music

**CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION
 VIA UNSECURE TRANSMISSIONS**

This consent form is for the communication of Protected Health Information (“PHI”) that SoundWell Music Therapy, PLLC may transmit without the written authorization of the client as described in the Uses and Disclosure section of SoundWell Music Therapy, PLLC’s Notice of Privacy Policies.

I, _____, hereby consent and authorize SoundWell Music Therapy, PLLC 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: faith@soundwellmusictherapy.com Send Receive
- N/A Appointment/Scheduling Reminder System
- _____ 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, SoundWell Music Therapy, PLLC cannot guarantee that those communications will remain confidential. Even though SoundWell Music Therapy, PLLC 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 SoundWell Music Therapy, PLLC 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 Name’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