Request for Transmission of Protected Health Information By Non-Secure Means

Member Name: _______ Date of Birth: _____
Member Address: _____ E-mail Address: _____
Number where you can be reached:_____

Alliance Health is required to encrypt all e-mail that contains Protected Health Information (PHI). You may request to receive unencrypted e-mail. Alliance wants you to understand the risks associated with using unencrypted e-mail. Some risks include, but are not limited to:

- Email may be easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email may be intercepted, altered, or used without detection or authorization. If intercepted, could possibly lead to identity theft.
- Email may spread computer viruses.
- Email delivery is not guaranteed.

Other alternatives to unsecured e-mail include US Mail, Landline telephones, Cellular phones, and faxes.
By signing below, I hereby authorize Alliance Health to transmit to me by *non-secure e-mail* the following types of protected health information related to my behavioral health records and health care treatment:

- Information related to the scheduling of meetings or other appointments
- Documents that may contain clinical and confidential information such as Person Centered Plans, Assessments, Medications
- Information related to billing and payment (which may include financial or claims-related information such as insurance plan numbers, diagnosis codes, or procedure codes.)

E-mail communication that contains documents requiring a signature may be sent using Docusign.

This consent extends to allow Alliance Health to send unencrypted e-mails to the provider/s working with the consumer. If you do not want Alliance to communicate with your provider/s through unencrypted e-mail, please initial here:_________.

For housing purposes (if applicable), I authorize Alliance to share my Name with potential property owners. Initial here: _____________.

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 consent in order to receive services from Alliance. I also understand that I may terminate this consent in writing at any time by notifying any Alliance employee.

This consent will expire at my request or when I am discharged from services.

______________________________	______________________________	____________
Member/Legally Responsible Person	Relationship	Date

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This Section for Agency Use Only

- ❑ **Request APPROVED**

Agency Requirements:
- ❑ Documentation of request approval
- ❑ Notification to staff of alternative communication method(s), as required)
- ❑ Notification to Business Associates, as needed

- ❑ **Request DENIED**

Reason for Denial:
- ❑ Too expensive to accommodate request
- ❑ Administratively impractical to accommodate request
- ❑ Failure of Client to specify an alternative accommodation

Alliance Staff Signature	Title	Date