AUBURN UNIVERSITY
PSYCHOLOGICAL SERVICES CENTER

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE EMAIL

I, _____ (_____)
[name of client if age 14+ or parent/guardian] [date of birth]

authorize Auburn University Psychological Services Center AUPSC; 101 Cary Hall, Auburn University, AL 36849; 334-844-4889 telepsc@auburn.edu) and specialty clinics listed below

Clinic Name	Email to communicate
Auburn Eating Disorder Clinic (AEDC)	aedc@auburn.edu
Autism Diagnostic Evaluations	telepsc@auburn.edu
DBT Skills Group	telepsc@auburn.edu
Parent Child Interaction Therapy (PCIT)	telepsc@auburn.edu

to transmit the following protected health information related to my health records and health care treatment by non-secure email.

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment **if applicable**
- Information received from a collateral party **if applicable**
- Client or session related attachments received from clinician, client or client's parent/guardian **if applicable**
- Other (specify): _____

This authorization is valid on _____
[email address to be used]

_____ _____
Email Recipient Name [if not client] Relationship to client [Parent, Caregiver, etc.]

and will expire either : _____ or _____.
[Date] [Event]

for the purposes of facilitating faster, more convenient communication with my clinician and AUPSC administrators. I understand that email will not be used for transmitting sensitive information, including but not limited to details of my mental health, mental health treatment, or treatment progress. I also understand that all emails between me and AUPSC will be documented.

I have been informed of the risks, including but not limited to my confidentiality in treatment and transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment and that there will be no consequences should I refuse to sign. I also understand that I may terminate this authorization at any time by contacting AUPSC.

_____ _____
[Signature of client if age 14 or older] [Date]

_____ _____
[Signature of parent/guardian] [Date]

_____ _____
[Graduate Clinician] [Date]

101 Cary Hall, Auburn, AL 36849-5234; Telephone: 334-844-4889; Fax: 334-844-6671

www.auburn.edu/aupsc