Aurora Mental Health Center
Live Life to the Fullest

1290 Chambers Road
Aurora, CO 80011
303.617.2300
aumhc.org

Clinicalrecords@aumhc.org

AUMHC SERVICES – NON-SECURE COMMUNICATION OF PROTECTED HEALTH INFORMATION (PHI)

Consent for Non-Secure Communication

_____
CID

_____ _____
Printed Client Name Date of Birth

I understand that the AuMHC has a secure (encrypted) e-mail. Despite that, I request that the AuMHC use non-secure (unencrypted) email, text and/or video messaging to communicate with me on the following:

- ❑ Communications regarding my appointments
- ❑ To send me copies of my medical records that I have requested
- ❑ For any communication about my mental health, therapy, treatments, and health care
- ❑ Other: _____

I request that AuMHC Services use the following option(s) for non-secure communication with me by use of the following:

❑ Personal email ❑ Text messaging (e.g. SMS) ❑ Video messaging (such as Facetime and Skype)

❑ Client verbally consents during this time of emergency.

_____
Name of clinician that heard verbal consent

_____ (_____)_____-_____
My email address My cell phone for text messages

I understand that non-secure e-mail may be intercepted by persons other than the sender and recipient. I accept all liability for any/all consequence of using this non-secure communication option. I release any/all AuMHC Services from any/all liability for using non-secure communication at my direction. I understand that I am not required to sign this agreement in order to receive treatment. I understand that I may terminate this consent at any time. This consent will remain in effect until I notify AuMHC Services in writing or by email that I revoke my permissions regarding this consent.

_____ _____
Signature of Client or Legal Representative Date

_____
Legal Representatives Relation to client
Documentation must accompany this form (unless already on file with AuMHC)