423 Weathersby Drive Suite 130, Hattiesburg, MS 39402
601-602-3624 • www.acceptedthearpy.com • acceptedthearpy@gmail.com

Consent for Release of Protected Health Information by Non-Secure Means

I, _____, authorize Nikki Dear, LCSW of Accepted Therapy Services to transmit to me by non-secure media the following types of protected health information related to may health records and health care treatment:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment

Termination of Consent

I understand that this authorization will expire 60 days from the termination of my therapy services.

I can also revoke this authorization in writing at any time by sending written notification to Nikki Dear, LCSW at 423 Weathersby Road Suite 130 or by email to acceptedthearpy@gmail.com. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive you written request to revoke authorization.

_____	_____
Printed Name	Signature
_____	_____
Legal Representative	Date