Patient Request for Unencrypted/Unsecured Protected Health Information (PHI)

You have the right to request copies of your medical records or billing records. You may also request that your medical records and billing information be provided to you or to designated individuals via unsecured or unencrypted device and/or transmission.

NOTICE OF POTENTIAL RISK

The transmission of your private information protected by this office, as required by the Health Insurance Portability and Accountability Act (HIPAA), by way of email or unencrypted mobile device includes some level of risk that the information transmitted might be accessed and read by an unauthorized third party. By authorizing transmission of your protected information by unencrypted email or via unsecured devices, you agree that this practice is not responsible for unauthorized access of your information while in transmission and is not responsible for safeguarding the information once it has been delivered.

To request that your private, protected health information be provided to you or your selected individual(s) by unencrypted transmission and/or unsecured devices, you must provide written authorization to do so. Failure to complete all items may result in denial of your request.

I, _____, hereby authorize Froeber Dentistry to
(Name of patient) (Name of Practice)
transmit my personal, protected health information to me by one or more of the following methods:

(PLEASE CHECK ALL THAT APPLY)

- ☐ **Unencrypted email**
- ☐ **Unsecured mobile device** (e.g., disc/USB drive/Flash drive)

DESCRIPTION OF INFORMATION TO BE TRANSMITTED

In the space below, describe the information to be transmitted, including descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.

Name of Patient or personal representative	
Signature of patient or personal representative	
Description of personal representative's authority to represent patient	
Date:	