Sound Connections
COUNSELING & CONSULTING, LLC

HIPAA SIGNATURE FORM

Your signature below indicates that you have read the form entitled, **"Notice of Sound Connections Counseling & Consulting, LLC's Policies and Practices to Protect the Privacy of Your Protected Health Information,"** related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Your signature indicates that you have had an opportunity to have questions answered and have received a copy of the form.

Client Name: _____ Date: _____

Signature of client or parent/guardian: _____

E-Mail Communication

Some clients/parents like the convenience of communicating with SCCC staff via e-mail. While our staff is more than willing to correspond via e-mail, it is important that clients understand that e-mail is not as secure as other forms of communication. E-mail messages can be intercepted as they travel over the internet. For this reason, we ask that you sign below **if you are interested in communicating via e-mail**. Your signature indicates that you understand and accept the risks to confidentiality that using e-mail involves. This form of communication could result in Personal Health Information (PHI) being intercepted by someone other than the person for whom it was intended.

Student Name: _____ Date: _____

I, _____, authorize SCCC staff to communicate with me via e-mail regarding service to me/my child.

Signature of client or parent/guardian: _____

E-mail address(es): _____

_____

☐ I do NOT wish to receive your client e-newsletter