CCG **Collaborative Counseling Group**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

I am required by law to maintain the privacy of your health information and to provide you with notice of my legal duties and privacy practices. I reserve the right to change my privacy policies as permitted by law and will notify you of any significant changes.

Treatment: I may use and disclose your health information to provide you with treatment and coordinate care (i.e. by communicating with physicians, psychiatrists, therapists, school or other professionals involved in your care.) This information will only be shared with your written consent to do so.

To Avert a Serious Threat to Health or Safety: When necessary to prevent a serious threat to the health or safety of yourself, the public, or another person, I may use or disclose your health information to individual(s) able to lessen or prevent the threatened harm.

Reporting Suspected Federal Violations and Child Abuse: Suspected Federal violations may be reported to appropriate authorities in accordance with Federal regulations. Federal laws and regulations do not protect any information about suspected child or elder abuse or neglect from being reported under State law to appropriate State or local authorities.

Special conditions regarding disclosure of psychiatric, substance abuse, and HIV related information

For disclosures concerning health information relating to care for psychiatric conditions, substance abuse or HIV-related information, special restrictions may apply. I generally may not disclose this information in response to a subpoena, unless you sign an authorization to do so or a judge orders the disclosure.

I consent to the use or disclosure of my protected health information by Collaborative Counseling Group (CCG) to any organization or person for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations.

2 Corporate Drive, Suite 209 Trumbull, CT 06611 (203) 220-6595

By signing below, I understand and acknowledge that I have read and understand this consent:

Print Name of Individual or Guardian

Signature of Individual or Guardian Date

Witness Date

Electronic Communications and Teletherapy

I am aware that email, texting and skype communication do not meet requirements to satisfy protected health information criteria set forth by HIPAA. By signing below, I acknowledge that by engaging in email, texting, skype or any other electronic means of communication with the staff and clinicians at Collaborative Counseling Group, I am hereby waiving my rights to any HIPAA protections provided pertaining to the transmission of such communications.

Teletherapy will be provided via a HIPAA compliant platform. However, there are specific risks to engaging in teletherapy. Despite best efforts to ensure high encryption and secure technology there is a risk of 1) the transmission of personal information 2) the connection could be disrupted or distorted by technical failures 2) the transmission of personal information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

I confirm that I understand the information above and by engaging in electronic communications or teletherapy am offering my consent.

Signature of Individual or Guardian Date