

APPENDIX II

FORM 3

CLAY COUNTY HIPAA AUTHORIZATION FOR TEXT MESSAGING

Clay County

HIPAA AUTHORIZATION FOR TEXT MESSAGING

As Clay County ("Clay County") would like to ensure that it is acting in accordance with your wishes, using your personal information with your authorization, and communicating with you in a manner with which you authorize, we ask you to fill out and sign this form. Clay County will keep a copy of your written permission on file.

There may be times when you wish to communicate with Clay County personnel via text messaging. Text messages sent via standard SMS/apple iMessage are not encrypted or secured. This means that text messages could be intercepted and read by a third party.

Clay County personnel will not engage in text messaging unless you complete the form below:

I specifically authorize text messaging communication with Clay County personnel. The phone numbers I want text communications sent to are those listed below, any phone number(s) which I provide directly, or any phone numbers from which I text that prompt a response. I understand that text message communications may be unsecured. I understand that a risk of unsecured text messages is the potential that the communication could be read by a third party and further compromised. I understand my mobile provider's standard rates for sending and receiving text messages will apply.

I am not required to sign this authorization. Clay County does not condition services on the signing of this form. I can request a copy of this authorization be mailed to me. I understand that I may revoke or withdraw this authorization at any time to prohibit future use of my information. To do so, I must send written notice to Clay County Social Services Director, 715 11th St N, Suite 502, Moorhead, MN 56560. I understand that Clay County, as well as other persons or entities, may retain copies of any electronic communications or printed versions and may retain these versions forever. Any revocation of this authorization will only extend to the versions of the information within my control that have not been previously published. If not revoked/withdrawn by me, this authorization expires as of the date my case is closed.

Name: _____

Signature: _____ Date: _____

Address: _____ (street address)
_____ (city) (state) (zip code)

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Phone Number(s): _____