**TELE-HEALTH INFORMED CONSENT**

I _____, consent to engaging in telehealth with Medical Support Services, Inc. as a part of the therapy process and my treatment goals. I understand that telehealth therapy may include evaluations, assessments, consultation, treatment planning, and therapeutic interventions. Telehealth will occur primarily through interactive audio, video, telephone, email and text messaging.

*"Telehealth is defined as "the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration" (Health Resources and Services Administration [HRSA], 2018)."*[1]

Medical Support Services has adopted current telehealth regulations.

I understand I have the following rights with respect to telehealth:

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2) The laws that protect the confidentiality of personal information also apply to telehealth. As such, I understand that the information released by me during the course of therapy sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

3) I understand that there are risks and consequences from telehealth including but not limited to, the unlikely possibility, despite reasonable efforts on the part of Medical Support Services Inc. that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

In addition, I understand that telehealth services is considered a form of direct service, and requires my full interaction and participation in my child's care to be an effective form of therapeutic intervention. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured.

4) I understand that Medical Support Services Inc. utilizes systems that are considered "END TO END ENCRYPTED" in order to meet HIPAA compliance. However, despite the best efforts of Medical Support Services Inc. we may have to utilize a variety of high performing telehealth systems we can not guarantee the use of audio/video systems are not 100% secure and may have issues with WiFi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Medical Support Services Inc. or its staff liable for gathering or use of client information by these service providers.

1. International Journal of Telemedicine: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6296796/ March 15,2020

Medical Support Services

5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my therapist, and all of my questions regarding the above matters have been answered to my approval.

6) By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based therapy services. If there is a crisis or an emergency I should immediately call 911 or go to the nearest hospital. If during the Telehealth session there is an emergency, the therapist is instructed to call 911 and send emergency assistance to you.

7) I understand that the Therapist from Medical Support Services is required to provide therapy to you from a secure/Private location. It is your responsibility to ensure that you are also in a secure location where only you, or people permitted by you could hear/witness you or your child's session.

_____

Signature of client/parent/guardian Date

_____

Printed name of client/parent/guardian Relationship (If applicable)