**Informed Consent for Participation in Telehealth**

Participant Name:

Participant Date of Birth:

I, , hereby consent to engage in telehealth with providers from Sunshine Therapy Services. I understand that "telehealth" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually.

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

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. Unless explicitly agreed otherwise, the telehealth exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. The laws that protect the confidentiality of my medical information also apply to telehealth. Just as with face-to-face clients, the provider will not release your information to anyone without your prior approval or required to do so by law.
3. I understand that this telehealth occurs in the state of Arizona, (USA), and is governed by the laws of that state. In a manner of speaking, you use modality to visit the provider in his/her Arizona office.
4. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
5. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if the provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.
6. I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
7. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my telehealth sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth session, (4) if I decide to keep copies of emails or communication on my computer, it is up to me to keep that information secure.
8. I understand that while email may be used to communicate with the provider, confidentiality of emails cannot be guaranteed.
9. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

**Informed Consent to The Use of Telehealth**

I, _____, have read and understand the information provided above regarding telehealth, have discussed it with my provider or such personnel as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth for services provided by Sunshine Therapy Services.

I choose, voluntarily, to participate in and have my child participate in services provided through telehealth technology. I understand this document will become a part of my child's medical record.

Client's Legal Representative:

Relationship to Child (please print):

Date:

_____
Signature