PHILLIPS
Programs for Children and Families

Related Services Telehealth Consent Form

During COVID-19 school closures/ schedule changes PHILLIPS Programs Related Service Providers will be delivering related services via telehealth. Telehealth is the practice of delivering clinical health care services via technology assisted media or electronic means between a licensed practitioner and a client who are located in two different locations. Telehealth is only available during the school closures/ schedule changes due to COVID-19. Upon school building's reopening, full time services will be provided in the school building per the student's IEP.

I understand the following with respect to telehealth:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future services or program benefits to which I would otherwise be entitled.
2. If consent is not provided or withdrawn, an IEP meeting will be held.
3. I understand that there are risks and consequences associated with telehealth including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and or limited ability to respond to emergencies.
4. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization except where the disclosure is permitted and/or required by law.
5. I understand that the privacy laws that protect confidentiality of my child's protected health information also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others).
6. I understand that during a telehealth session we could encounter technical difficulties resulting in service interruptions. If this occurs the service provider will attempt to re-engage or re-schedule the session.
7. I understand that my therapist may need to contact my emergency contact and or appropriate authorities in case of emergency.
8. I understand that if my child is having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that my child needs a higher level of care and for emergency services to be involved/ notified.

Emergency Protocol:

In the case of an emergency I agree to inform telehealth providers of the address where my child/student will be located during telehealth services and to inform them of any changes in address at the beginning of telehealth sessions.

Emergency Contact (name and phone number) if I cannot be reached during telehealth services:

Address where my child/student will be during telehealth sessions:

☐ I have read and acknowledge the consents for my child to participate in telehealth services, to include:

- ☐ counseling
- ☐ speech and language therapy
- ☐ occupational therapy

as indicated on my child's IEP.

Signature of parent/legal guardian Date

Signature of Related Service Provider Date

Signature of Related Service Provider Date

Signature of Related Service Provider Date

Signature of Related Service Provider Date