Sample Consent for Services Provided Via Telepractice Form

CONSENT FOR TELE-INTERVENTION SERVICES

Child's Name:_____ Date of Birth:_____

Address: _____

Parent/ Guardian: _____

Introduction

Teleintervention through ABC Agency is the delivery of services using distance technology when the provider and the family are not in the same location. Electronically transmitted information may be used for diagnosis, intervention, consultation, follow-up, parent or caregiver education, counseling, and information sharing. This may include any of the following:

- Child clinical or educational records;
- Interactive audio, video and/or data communication; and/or
- Output from audio or video files, including audio clips, photos and video files

The interactive electronic systems (i.e. videoconferencing equipment, hardware & software) used for service delivery incorporate network and software security protocols to protect the confidentiality of child/family information and to safeguard all transmitted audio and video information against intentional and unintentional corruption.

Potential Benefits

1. Improving access to specialized educational or clinical services
2. Obtaining the expertise of a distant specialist or consultant for me or my child's team
3. Empower me to work directly with my own child with the support of these specialists

Potential Risks

As with any service delivery model, there may be potential risks associated with the use of teleintervention. These risks include, but may not be limited to:

1. At times, information transmitted may not be sufficient (e.g., poor resolution of images or audio interference) to allow for appropriate clinical decision making by the clinician or distant specialist.
2. The distant specialist or clinician may not be able to provide all necessary services that are required to adequately address all needs.
3. Security protocols could fail, causing a breach of privacy of confidential clinical/medical information.

*This form is an example of a telepractice consent form and is not required by DCYF

By signing this form, I understand and agree with the following:

1. The laws that protect the privacy and confidentiality of medical information also apply to teleintervention. Information obtained during a teleintervention encounter, which identifies me, my child/dependent(s), should not be disclosed to any third party without my consent except for the purposes of treatment, payment, and healthcare operations.
2. I understand that other individuals other than my provider may also be present and have access to my information during the consultation or session in order to operate or repair video or audio equipment, should such equipment be utilized.
3. I have the right to withhold or withdraw my consent to the use of teleintervention during the course of my care at anytime
4. I have the right to inspect information obtained during the course of an interaction and may receive copies of this information. Such inspection and copying of records shall be subject to my provider's office policies and procedures.

Parent/Caregiver Consent to the Use of Teleintervention Services

I have read and understand the information provided above regarding teleintervention, have discussed this with my provider and all my questions have been answered to my satisfaction. I hereby give my informed consent to use teleintervention for my child.

I hereby consent to and authorize ABC Agency to use teleintervention in the course of my child's services.

Name of Child: _____

Parent/ Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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