CLARITY HEALTHCARE and PARIS R-II SCHOOLS

Full Name:_____

Social Security #:_____ Date of Birth:_____

Understand that:

- As a consumer of Preferred Family Healthcare there may be healthcare services to treat mental health and/or physical health and wellness available to me through participation in Telehealth services. I understand that participation in Telehealth services is not a requirement of receiving other services through Preferred Family Healthcare and I can refuse to participate in Telehealth services at any time without affecting my right to future care and treatment through Preferred Family Healthcare.

- I will be informed of alternative resources to receiving needed care other than those provided through Telehealth services and understand that all services are voluntary and that Preferred Family Healthcare is not mandated to obtain needed services for me outside of the realm of care provided directly by Preferred Family Healthcare but does so in order to enhance the quality of care provided.

- Any medical information as a product of Telehealth services are subject to the same confidentiality laws as services provided in person and that I have a legal right to that information as provided by law.

- There will be no dissemination, storage or retention of the video interaction produced through the Telehealth service provision.

- I will be informed of all parties who are present at the originating site and the distant site during the Telehealth service provision and I have the right to exclude anyone from either site at my request.

- I will be provided with emergency contact information should a mental health or medical emergency arise.

- My records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2, and the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and cannot be disclosed without written consent unless otherwise provided for in the regulations.

- I may revoke this consent at any time, except to the extent that services have already been provided in reliance on this or any other consent. Revocation may be accomplished per written request and may be for specific items or the entire release.

This consent will automatically expire1 year from date of signature unless there is a different specification of date, event, or condition noted._____

I understand that Preferred Family Healthcare may not generally condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Would you like a copy of this authorization? Please initial: ( ) YES ( ) NO
If yes, copies will be mailed to you if not provided immediately.

Signature of Client:_____ Date:_____

Signature of Parent/Guardian/Legal Rep:_____ Date:_____

(Specify relationship to client:_____)