



MALLARDS COUNTY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Telehealth Acknowledgement/Consent



Name:	
SS#:	DOB:
Address:	
Phone #:	Alternate Phone #:
School:	

I understand that:

- As a consumer of Clarity Healthcare/Preferred Family Healthcare, Inc. 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 Clarity Healthcare/Preferred Family Healthcare, Inc. and I can refuse to participate in telehealth services at any time without affecting my right to future care and treatment.
- 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 Clarity Healthcare/Preferred Family Healthcare, Inc. is not mandated to obtain needed services for me outside of the realm of care provided directly by Clarity Healthcare/Preferred Family Healthcare, Inc. 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 C.F.R. part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA) 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 expire one year from date of signature unless there is a different specification of date, event or condition noted.
- I understand that Clarity Healthcare/Preferred Family Healthcare, Inc. 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.

Signature of client:	Date:
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Signature of parent/guardian/legal representative:	Date:	Relationship to client:
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If you would like a copy of this authorization, please initial: _____ Yes _____ No Witness Initials: _____