Southlake Autism and Behavior Services, PA
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Authorization and Consent to Participate in Telehealth Sessions

The purpose of this form is to obtain parental/guardian consent for their child/children to participate in telehealth sessions and remote supervision with registered behavior technicians and certified staff of Southlake Autism and Behavior Services.

1) Purpose and Benefits: The purpose of the telehealth session is to enable clients to access behavioral health services and enhance the efficiency of the therapeutic service delivery system. Telehealth is not a distinct service, but it is a way that allows therapists to deliver health care to their patients in a way that approximates in-person care. The standard of care is the same whether the patient is seen in-person or through telehealth.

2) Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation. All existing confidentiality protections under federal and State of Florida law apply to information disclosed during this telehealth consultation. The consultation is conducted using HIPAA compliant video software.

3) Risks and Consequences: The telehealth session will consist of interactive video technology that will allow you to communicate with the therapist at a distance and will allow a BCBA to provide routine consultation/supervision, educational services, and feedback at a distance.

4) Rights: You may withdraw consent for any telehealth session or consultation at any time without impact on your right to future care or treatment, or without risking withdrawal from program benefits to which you would otherwise be entitled.

☐ I have been advised of all the potential benefits, risks, and consequences of the telehealth sessions. I have had the opportunity to ask questions about the telehealth sessions and have received answers to any questions that have been posed. I understand the written information provided above and I consent to my child/children participating in telehealth sessions with Southlake Autism and Behavior Services.

☐ I have been advised of all the potential benefits, risks, and consequences of the telehealth sessions. I have had the opportunity to ask questions about the telehealth sessions and have received answers to any questions that have been posed. I understand the written information provided above, however I do not consent to my child/children participating in telehealth sessions with Southlake Autism and Behavior Services and would like to continue to receive services at the office of Southlake Autism and Behavior Services.

Parent/Caregiver (Print Name): _____

Parent/Caregiver (Signature): _____

Date: _____

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