Name of Patient_____

AUTHORIZATION FOR TELEHEALTH TREATMENT

The purpose of this form is to obtain your consent for you and/or your child to participate in treatment through telehealth provided by an Achieve Center clinician.

- The nature of the telehealth treatment appointments are to enable treatment to continue during the public health emergency, Covid-19 and will focus on the goals which you have or will establish with the therapist. Telehealth treatment is governed by federal and state laws which, has previously had limitations on its use, and its availability after the cancelation of the public health emergency has not yet been determined.

- All existing laws regarding your access to information and copies of your records apply to telehealth treatment sessions.
  IMPORTANT: At <u>no time</u> will the telehealth treatment session be recorded or stored.

- Reasonable and appropriate efforts have been made to avoid any confidentiality risks associated with utilizing telehealth for treatment sessions. All existing confidentiality protections under federal and state law apply to information disclosed during the telehealth treatment session.
  IMPORTANT: The Achieve Center <u>cannot assume</u> responsibility for confidentiality breaches which could occur due to your computer being unsecured or being located in an area accessible or within hearing range of others.

- **IMPORTANT: You may withhold or withdraw your consent to the telehealth treatment sessions at any time without affecting your right to future treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.**

- If you believe that any of your rights have been violated, you have the right to talk with the Client Rights Specialist, Yvonne Zais, if you would like to file a grievance or learn more about the grievance procedure

- You have been previously been advised of your rights both verbally and in writing when you originally consented to treatment. A copy of your Client Rights is available upon request. Prior to your signing or after you have signed this authorization, if you have any questions related to this authorization or telehealth treatment sessions, please discuss them with your therapist, Client Rights Specialist Yvonne Zais, or the Executive Director Carol Wesley.

  I hereby agree that I and/or my child will participate in telehealth treatment sessions provided by the Achieve Center.

_____ _____

Signature of Patient or Parent/Guardian Date Signature of Minor Patient age 14 Yrs > Date

_____

Email Address