Professional Counseling Associates

Services provided by

arisa health

For Health. For Hope. For You.

Authorization & Consent to Telehealth

Client Name:_____Date:_____

- I understand my image and Protected Health Information will be transmitted electronically through the telehealth equipment to behavioral health providers, physicians and other healthcare professionals for the purpose of providing behavioral health treatment including but not limited to therapy, treatment planning, crisis assessment and treatment recommendations.
- I understand that even though the likelihood of this transmission being intercepted by unauthorized persons is extremely small, there is a chance this could happen.
- I understand I may withdraw my permission at any time prior to, or during the telehealth session.
- I understand that if I do withdraw my permission, no action will be taken against me.
- I understand that if the telehealth session is interrupted, it will be considered incomplete and the healthcare professionals involved in the videoconference will be unable to provide services to me at that time.
- I understand that I may still get a consultation with another healthcare professional.
- I understand that that telehealth technology is limited and there is no guarantee that this telehealtth session will eliminate the need for me to see a specialist in person in order to receive the appropriate, or additional treatment for my condition.

"In accordance with Governor Hutchinson's EO 20-05, I have reviewed that services will be conducted during the COVID-19 outbreak via telehealth using video or phone." I have reviewed this information with the client via phone and have obtained their verbal consent".

o Yes

o No

_____ _ _____

Signature of Client or Legal Representative of Client Date

_____ _ _____

Witness Signature Date