Amaryllis
THERAPY NETWORK

Permission for Telehealth Services

Amaryllis Therapy Network has always been a child and family centered clinic. We understand that there are times when face-to-face contact might not be in your family's best interest. With that in mind, our clinic is offering Telehealth for occupational therapy, speech therapy and physical therapy services.

I, _____, give consent for my child to engage in Telehealth services with Amaryllis Therapy Network. I understand that teletherapy includes treatment using interactive audio, video, and/or data communications. I understand that teletherapy also involves the communication of my child's medical information.

I acknowledge the following (***please initial***):

_____ I understand that I have the right to withhold or withdraw consent at any time without affecting my child's right to future care or treatment.

_____ I understand that the laws that protect the confidentiality of my medical information also apply to Telehealth. As such, I understand that the information disclosed during the course of my child's therapy services is confidential.

_____ I understand that I will have access to all medical information resulting from Telehealth services as provided by applicable law to my child's medical records.

_____ I understand that there are risks associated with teletherapy services, despite reasonable efforts on the part of Amaryllis Therapy Network. I understand that the transmission of my information could be disrupted or distorted by technical failures and that the transmission of my information and/or services could be interrupted. Amaryllis Therapy Network currently uses Zoom to provide HIPPA compliant teletherapy services.

Child's Name: _____
(Please Print)

Parent/Guardian's Name: _____
(Please Print)

_____ _____
Parent/Guardian's Signature Date