PERMISSION TO PROVIDE SERVICES VIA WEB CAMERA and/or TELEHEALTH

This information is entirely confidential

To best serve your child and family, it may be necessary to utilize our web camera and/or Telehealth services. This is a camera connected to a computer that transmits and records audio and video over the internet. It may be necessary to share this information with other individuals or agencies who are involved with your child. Information to be shared is limited to what is necessary to enable us to work effectively with you and your child.

Child: _____ Birthdate (mm/dd/yy): _____/_____/_____

Address: _____

City/Town:_____ Postal Code:_____

In order to quickly provide information to you or other professionals providing service to your child, we use Telehealth and/or web camera services over the internet. We take precautions to protect your privacy. However, you need to be aware that sending information over the internet does include the risk of personal information being accidentally disclosed to other people (e.g. on the web). For this reason we need your permission to utilize our Telehealth and/or web camera services.

_____**Yes**, I give my permission to utilize ☐Telehealth and/or ☐web camera services.

_____**No,** I do not give permission to utilize Telehealth and/or web camera services.

_____	_____	_____/_____/_____
Name of Legal Guardian	Signature	Date (mm/dd/yy)