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## TELEHEALTH / ELECTRONIC COMMUNICATION CONSENT

I hereby give consent to participate in therapy and counseling through telehealth services. Telehealth services will include the use of secure, HIPPA compliant technologies. I further give consent for my provider to use voice, video, email and text messaging as a form of communication regarding scheduling and confirming appointments. By signing below I understand that:

- (a) I as the patient, retain the option to refuse the telehealth consultation at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
  - (b) All existing confidentiality protections shall apply to the telehealth consultation.
  - (c) I as the patient shall have access to all medical information resulting from the telehealth consultation as provided by law for patient access to his or her medical records.
  - (d) I as the patient understand that dissemination of any identifiable images or information from the telehealth consultation to researchers or other entities shall not occur without my written consent.
  - (e) I understand that no portion of telehealth services will be recorded by myself or the provider.
- Laws 1999, LB 559, § 5

X-----

Patient / Guardian Signature above

X-----

DATE

**Patient** PRINTED NAME above