**Authorization and Consent to Participate in Tele-Health Consultation**

The purpose of this form is to obtain your consent to participate in tele-health consultation and remote supervision with

the BCBA.

1) Purpose and Benefits. The purpose of the tele-health consultation is to enable clients living in rural and/or

underserved areas to obtain access to specialists without the time and expense of travel.

2) Confidentiality. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks

associated with the tele-health consultation. All existing confidentiality protections under federal and State of \_\_\_\_\_

law apply to information disclosed during this tele-health consultation. The consultation is conducted using HIPAA

compliant video software.

3) Risks and Consequences. The tele-health consultation will be similar to routine BCBA consultation/supervision,

except interactive video technology will allow you to communicate with the BCBA at a distance, and will allow the BCBA

to observe the RBT working with the client and provide feedback at a distance. The use of video technology to deliver

behavioral healthcare and educational services is a new technology and may not be equivalent to direct client to

provider contact.

4) Rights. You may withdraw consent for any tele-health session or consultation at any time without impact on your

right to future care or treatment, or without risking withdrawal from program benefits to which you would otherwise be

entitled.

\_\_\_ I have been advised of all the potential benefits, risks, and consequences the tele-health sessions. I have had

opportunity to ask questions about the tele-health sessions and have received answers to any questions that have

been posed. I understand the written information provided above.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_