OUT EAST THERAPY OF NEW YORK

CONSENT FOR THE USE OF TELEHEALTH

Child's Name: ________________________________ DOB: ______________________________

Address:____

City/Town: ____________________________________ State: New York Zip Code:____________

Services Type to Be Delivered Using

Telehealth:_____________________ District/School_________________

Name of Therapist/Teacher: ______________________________ Phone # ______________________

Service Provider Agency: Out East Therapy of NY: Phone #: 631-874-0571

I, (Parent/Guardian's Full Name)____, consent to have my child's (enter service type)______________________________________ service delivered using Telehealth as a related service delivery method. I understand that the Telehealth services that my child will be receiving will fulfill the service mandate in my child's Individualized Education Plan (IEP) and are not being delivered in addition to the home/community-based services that my child is authorized to receive.

I understand that if my child's IEP recommends "group" services he or she may be grouped with other children on the computer who will be able to see my child and the background in which my child is in.

I understand that Telehealth means that related services will be delivered using an audio and video at the same time for the duration of the session. Telehealth does not mean having a telephone call with my child's therapist/teacher.

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Parent Name (Print)

____ ______________________

Parent Signature Date

I, (Parent/Guardian's Full Name)____, DO NOT consent to have my child's

(enter service type)______________________________________ service delivered using Telehealth as a related

service delivery method.

____

Parent Name (Print)

____ ______________________

Parent Signature Date