TASC
Treatment Alternatives for Safe Communities

Consent for Telehealth Services

I, _____ [insert client's name here], whose birthdate is ____/____/____ [insert DOB], agree to participate in Telehealth Services provided by TASC, Inc.

Telehealth Services include healthcare, mental health, substance use disorder treatment, and related services to a patient regardless of their location through electronic or telephonic methods, such as telephone (landline or cellular), video technology commonly available on smart phones and other devices, and video conferencing.

I understand that I am not required to agree to the use of Telehealth Services, and I retain the right to discontinue the use of Telehealth Services and revoke this consent at any time in writing without affecting my right to future care or treatment. I further understand that a revocation will be effective immediately, but not to the extent that the consent has been previously acted on. If not previously revoked, this consent for Telehealth Services expires on the following date (if not otherwise stated, this date shall be one (1) year from the date of this consent): _____.

I understand that while TASC will take all reasonable efforts to reduce the confidentiality risks of Telehealth Services, TASC cannot guarantee their privacy or security. Third-party applications potentially introduce privacy risks. Among other things, the transmission of my personal information could be disrupted or distorted by technical failures, or interrupted by unauthorized persons. In order to protect my confidentiality, TASC enables all available encryption and privacy modes and only uses non-public facing remote communication products.

I understand that the disclosure of confidential information is governed by State and Federal laws and regulations pertaining to the Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2), the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 45 CFR Parts 160 & 164), and/or the Illinois Mental Health and Developmental Disabilities Confidentiality Act. TASC's Notice of Privacy Practices also applies to Telehealth Services. My confidential information will not be disclosed without my consent, or as otherwise required by law.

_____

Client Signature Date

_____

Client's Parent/Guardian/Authorized Representative Name (please print)

_____

Client's Parent/Guardian/Authorized Representative Signature (if applicable) Date

_____

TASC Staff/Witness Attesting to Identity Signature Date

For Internal Use:

Client Name (Last, First): _____ **Client Date of Birth:** _____