2209 E Market St
York, PA 17402
Phone: (717)759-1024

Telehealth Consent Form

As of January 1, 2026

Client name____
DOB____

Phone number____ Email_____________________________

The purpose of this consent form is to obtain your consent for you, the client, to participate in telehealth sessions with your provider. By signing the consent form, you agree to participate in telehealth group, family, couples and/or individual sessions with Therapeutic Family Connections, LLC.

All existing laws regarding your access to treatment information apply during telehealth sessions. The telehealth sessions will not be recorded or stored. Reasonable and appropriate efforts have been made to eliminate confidentiality risks associated with telehealth services, and all existing confidentiality under federal and state laws apply to information disclosed during all telehealth sessions.

The system that will be used during telehealth sessions is HIPPA compliant; however, it is your responsibility as the client to be in a private environment to ensure that your information, and the information of others during the session, is protected.

Individuals that participate in group, family, or couples' telehealth sessions are prohibited from recording the session in any fashion, sharing any client information, taking photos or screenshots of participants or facilitates, or allowing nonapproved individuals to participate or have access to the session. Failure to abide by these requirements can result in program suspension or participation.

The provider has the right to refuse completing the telehealth session if he/she feels that the surrounding environment is not appropriate for the session or private enough to protect the privacy of the client(s) or group participant.

A safety plan must be in place if you are choosing to complete telehealth sessions. Please note that if the provider is concerned about your safety and a safety plan has not been established, local law enforcement agencies can be dispatched for a welfare check. Communication to order medical centers can also occur if the situation is deemed necessary.

By signing this form, I agree to my acknowledgement of the terms above and agree to follow said terms.

CLIENT SIGNATURE_______________________________________ DATE_______________________

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I______________________________ give my consent for__________________________________, DOB___________________________, to engage in telehealth services provided by Therapeutic Family Connections, LLC. Telehealth services are provided via internet technology that includes and is not limited to telephone conversations, interactive audio, video, or data communications. I understand that telehealth involves communication of my medical / mental health information both orally and / or visually. (For children under 14 years old)