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PERMISSION TO USE TELEHEALTH DURING THE PROVISION OF PSYCHOLOGICAL SERVICES

This permission is being requested of you due to new regulations recently implemented by the Michigan Board of Psychology and Licensing and Regulatory Affairs (LARA) of the State of Michigan.

I, ______________________________the parent/legal guardian of ________________________
DOB: _________________________ grant permission for the use of telehealth when necessary and agreed upon for diagnostic, treatment or consultation services regarding my minor child. I grant this permission knowing that my child and their parent(s) may participate with this technology.

I understand Dr. Miller utilizes ZOOM (HEALTHCARE). I understand that the platform is HIPAA compliant and a breach of this technology is unlikely. I further understand that appointments are not taped or stored in any format. I understand that we may exit a session at any time.

I understand that all PHI (Personal Health Information) and billing information is secure per HIPAA regulations and is stored on a non integrated server from ZOOM (HEALTHCARE)..

I understand that I may revoke this permission at any time by written notice via email, letter or in person.

//sig: Parent/Guardian Signature:____

Date:______________________________________