Preschool Parental Consent to Use E-mail to Exchange Personally Identifiable Information During COVID-19 Emergency

Child's Name: ___________________________D.O.B. _________________
Parent's Name ____
E-mail Address: ____

At your request, you have chosen to communicate personally identifiable information concerning your child's preschool services by e-mail without the use of encryption. Sending personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the parent.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

Parental Acknowledgement and Agreement

I acknowledge that I have read and understand the items above which describe the inherent risks of using e-mail to communicate personally identifiable information. Nevertheless, I, ______________________________________, authorize ________________________________ whose e-mail address is __________________ to communicate with me at my e-mail address, ______________________________________, concerning my child's, ____________________________________, participation in the Preschool Telepractice Related Services including but not limited to communication regarding service delivery, his/her progress and any other related matters. I understand that use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.

(Optional) In addition, I give permission for members of my child's treatment team to communicate personally identifiable information concerning my child with each other using unencrypted e-mail. Preschool team members who I give permission to use unencrypted e-mail to communicate with each other about my child include:
(1) _________________________ with the e-mail address_______________________________
(2) __________________________with the e-mail address_______________________________
(3) __________________________ with the e-mail address ______________________________
(4) __________________________ with the e-mail address ______________________________

Parent's Signature ____Date _______________

SUFFOLK COUNTY PRESCHOOL

CONSENT FOR THE USE OF TELEPRACTICE DURING DECLARED STATE OF EMERGENCY FOR COVID-19
AUDIO and VIDEO

Student's Name:		School District:		DOB: / /
Address:				Apt #:
City/Town:		State: New York	Zip Code:	
Service Type to Be Delivered Using Telepractice:	Service Mandate:			
Name of Therapist/Teacher:	Phone #:			
	Email:			

Instructions: This consent form for the use of Telepractice as a service delivery method for the provision of CPSE services must be completed for each service type authorized for the above referenced student before telepractice services can be initiated. Telepractice as a preschool related service / SEIS delivery method is only available *during the declared state of emergency* for COVID-19.

A consent form for the use of Telepractice can be returned by email if the parent/guardian also signs and returns the Suffolk County Parental Approval to Use E-mail to Exchange Personally Identifiable Information.
The consent form for the use of Telepractice must be signed and returned prior to the initiation of services. A separate consent form is required for each service.

I, (Parent/Guardian's Full Name) ____, consent to have my child's

(enter service type)________________________________service delivered using Telepractice as a service delivery method for Related Services/SEIS services listed on his/her IEP. I understand that the Telepractice 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 services that my child is authorized to receive.

I understand that Telepractice a preschool related service/SEIS service delivery method is only available during the declared state of emergency for COVID-19 and that my child's services will be delivered using the method authorized in my child's IEP after the declared state of emergency.

I understand that Telepractice means that the CPSE services will be delivered using **an audio and video at the same time** for the duration of the session.

My child's therapist/teacher has explained how the service will be delivered and I further understand my role in assisting with the service delivery.

I understand that I will have access to all information resulting from the sessions conducted via Telepractice in the same way I would when services are delivered as per the mandated IEP.

☐ By checking this box, parent confirms:
- provider called to obtain verbal consent on ____/____/____ for immediate initiation of telepractice services
- parent will sign and email the form back to provider within 48 hours of receipt via email or US mail

____
Parent Name (Print)

____ _______________________
Parent Signature Date

Suffolk County CPSE Weekly Confirmation of Telepractice Services for COVID-19

Instructions: This form must be completed by the teacher/therapist to ensure the continuation of services during the Declared State of Emergency for COVID-19. All fields are required. All information must be completed and must match the appropriate fields on accompanying session notes. The form should be completed WEEKLY, signed by the parent/caregiver who participated in the session. **Typed signatures are not acceptable.** Please maintain the original document with your files and submit copy with your billing. Teletherapy services must be supported by NYSED guidance and the Governor's State of Emergency and may not be permitted once the State of Emergency is lifted.

Child's Name:	**DOB:**	**School District:**
Service Type Delivered (One IEP Mandate Per Sheet):		
Teacher/Therapist Name:	**Teacher/Therapist Discipline:**	**NPI#:**
Agency Name:	**Frequency:**	**Intensity:**

Date of Service	Start Time	End Time	CPT Code	Signature of Parent/Guardian Verifying That Service Was Delivered	Date Signed