

# Lily Health and Wellness Center

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## Consent for Electronic Communication and Telehealth Services

This document outlines the terms and conditions under which Lily Health and Wellness Center (LHW) may communicate with you electronically and provide telehealth services. Please review this information carefully before signing.

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### Authorization for Electronic Communication

I hereby authorize **Lily Health and Wellness Center (LHW)** to communicate with me—and, when applicable, with other professionals involved in my care or my child's care—through electronic means. These methods may include secure email and standard LHW messaging systems for purposes such as appointment reminders, scheduling updates, and administrative communications.

I acknowledge that LHW utilizes secure, encrypted email services. I further understand that telephone calls and standard text (SMS) messaging are not encrypted and that the confidentiality of information transmitted through these methods cannot be fully guaranteed. By providing this consent, I agree that Lily Health and Wellness Center and its employees shall not be held liable for any breach of confidentiality resulting from unauthorized access to information contained in standard SMS messages related to my appointment or my child's appointment.

LHW will take reasonable and appropriate measures to safeguard the privacy and security of electronic communications. All electronic correspondence containing personal health information will be maintained as part of my medical record and will be accessible only to authorized health care providers, treating clinicians, insurance carriers, and designated administrative staff. My email and SMS communications will not be shared outside of Lily Health and Wellness Center without my written authorization, except as required by law.

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### Telehealth Consent (Zoom Platform)

I voluntarily consent to participate in telehealth services provided by Lily Health and Wellness Center using the Zoom platform. By signing below, I acknowledge, understand, and agree to the following:

- Telehealth services are subject to the same standards of confidentiality and privacy as in-person clinical services.

- Telehealth involves inherent risks, including but not limited to technical difficulties, service interruptions, or the possibility of unauthorized access to electronically stored or transmitted information.
- I am responsible for ensuring that my environment during telehealth sessions is private and secure to protect my confidentiality.
- I agree to inform my provider of my current physical location at the beginning of each telehealth session to allow for appropriate care and emergency response if necessary.
- Audio or video recording capabilities may exist within telehealth platforms. Neither I nor my provider may record sessions without the prior written consent of both parties.

Lily Health and Wellness Center utilizes Zoom as its telehealth platform. I understand that Zoom may be configured to comply with HIPAA standards and that reasonable safeguards are in place to protect my information; however, I acknowledge that no electronic system can guarantee absolute security. If I prefer not to receive services via Zoom, I may elect to receive care in person, subject to provider availability.

By consenting to telehealth services, I agree not to hold Lily Health and Wellness Center or its employees liable for breaches of confidentiality resulting from circumstances beyond the Center's reasonable control, including unauthorized access to telehealth communications. I understand that all telehealth-related communications and clinical information will become part of my medical record and may be reviewed by authorized health care providers, insurance entities, and administrative personnel as permitted by law.

## Acknowledgment and Signature

**Client / Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Client / Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Parent or Legal Guardian Authorization (if applicable)

I certify that I am the parent or legal guardian of the minor named above and that I have the legal authority to provide consent for electronic communication and telehealth services on the minor's behalf.

**Guardian Name:** \_\_\_\_\_

**Relationship to Client:** \_\_\_\_\_

**Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_