Telehealth Consent Form

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NOTE: This is the patient's name. If you are filling this form out on behalf of your child or the patient, please be sure to use the patient's name, NOT your name.

CLIENT NAME (Printed): _____

Patient's Date Of Birth: _____

Consent to TeleMental Health Treatment

Telemental health involves the use of electronic communications to enable providers to engage in clinical mental health services when the client and provider are at different locations and may include Live two-way audio and video.

- Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to care, reduced travel time, and allows a patient to participate in therapy from whatever environment they feel most comfortable.

Possible Risks:

Potential risks associated with the use of telemental health include, but may not be limited to:

- Disruption of transmission by technology failures;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information; Limited ability to respond to emergency situations;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telemental health, and that no information obtained in the use of telemental health which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemental health in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there will be no recording of any of the online sessions by either party. All the information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization except where the disclosure is permitted and/or required by law.
4. I understand that a variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time.
5. I understand that telemental health may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.
6. I understand that I may expect the anticipated benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.
7. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that it is my responsibility to let my provider know.
8. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health sessions are not appropriate and other care is required.
9. I also understand that telemental health may not be the most effective form of treatment for certain individuals or presenting problems. If the provider believes that the patient would benefit more from another type of service, such as face to face sessions, or from another provider, a referral will be made.
10. I understand that during my session I should be in a quiet private place and should not be driving or operating machinery.

Are you the patient or parent/guardian of the patient? (Check One)* Patient _____ Parent/Guardian _____

Patient Consent To The Use of Telemental health

I have read and understand the information provided above regarding telemental health. I hereby give my informed consent for the use of telemental health in my care.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Patient Consent To The Use of Telemental health

I have read and understand the information provided above regarding telemental health. I hereby give my informed consent for the use of telemental health for the patient's care.

Parent/Guardian Printed Name: _____

Relationship to Patient: _____

Parent/Guardian Signature: _____ Date: _____