



Telehealth Informed Consent

Telehealth is the practice of delivering healthcare services through the use of electronic communications (i.e. computer, phone, tablet) between a provider and a client who are in two different locations. You will be responsible for creating a safe and confidential space during sessions. You should use a space that is free of other people. It should also be difficult or impossible for people outside the space to see or hear your interactions with your provider during the session. At the first session, a plan will be developed for backup communications in case of technology failures and a plan for responding to emergencies and mental health crises.

I understand the following with respect to Telehealth:

1. I understand I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with Telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my provider may record the sessions without the other party's written permission. All 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 the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others).
5. 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 Telehealth services are not appropriate and a higher level of care is required.

6. I understand that during a Telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.

7. I understand that my provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

As a recipient of Telehealth services, you will need to participate in ensuring your safety during mental health crises, medical emergencies, and sessions that you have with your provider. Your provider will require you to designate an emergency contact. You will need to provide permission for your provider to communicate with this person about your care during emergencies. Your provider will also develop with you a plan for what to do during mental health crises and emergencies, and a plan for how to keep your space safe during sessions. If your safety is at risk, call 911.

Emergency Contact:

Name and Relationship to Client: _____

Address and Phone Number: _____

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

Client Name	Signature	Date
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Guardian Name (if applicable)	Guardian Signature	Date
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Witness Name	Witness Signature	Date
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