Informed Consent for Telehealth Services

CLIENT NAME: _____ LOCATION OF CLIENT: _____	DATE OF BIRTH: _____	MEDICAL RECORD #: _____
COUNSELOR/THERAPIST: _____ LOCATION: _____		DATE CONSENT DISCUSSED: _____

Introduction

Online psychotherapy, also known as telemental health services ("telehealth"), involves a therapist or counselor providing psychological counseling and support over the Internet through email, video conferencing, online chat, or phone calls. The information may be used for diagnosis, therapy, follow-up and/or education.

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 to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to mental health services by enabling the client to remain in his/her home or other remote site.
- Mental health services are more accessible and convenient—increasing mental health treatment outcomes.
- More efficient evaluation and continuity of mental health services.

Possible Risks:

There are potential risks associated with the use of telehealth services. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient to allow for appropriate decision making by the counselor/therapist;
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal information;

Please initial after reading this page: _____

By signing this form, I understand the following:

1. I understand the laws that protect privacy and the confidentiality of information also apply to telehealth services, and no information obtained in the use of this service which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand I have the right to inspect all information obtained and recorded in the course of a telehealth session, and I may receive copies of this information.
4. I understand that a variety of alternative methods of therapeutic care may be available to me, and that I may choose one or more of these at any time. My counselor/therapist has explained the alternatives to my satisfaction.
5. I understand telehealth services may involve electronic communication of my personal information.
6. I understand I may expect benefits from the use of telehealth services, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telehealth Services

I have read and understand the information provided above regarding telehealth. I have discussed it with my counselor/therapist, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my psychotherapeutic care.

I hereby authorize _____ ***(name of counselor/therapist)*** to use telehealth in the course of my diagnosis, evaluation, and treatment.

Signature of Client (or person authorized to sign for patient): _____ *Date:* _____

If authorized signer, relationship to client: _____

Witness: _____ *Date:* _____

I have been offered a copy of this consent form (client initials) _____