CONSENT TO PARTICIPATE IN TELEHEALTH CONSULTATION

Name: _____ **Date:** _____

1. PURPOSE. The purpose of this form is to obtain your consent for a telehealth session with your provider. The purpose of this consultation is to assist with your diagnosis and treatment.

2. NATURE OF TELEHEALTH CONSULTATION. Telehealth involves the use of electronic communications to enable professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education and the transfer of medical and clinical data.

3. RISKS, BENEFITS AND ALTERNATIVES. The potential risks to telehealth technology include interruptions, unauthorized access and technical difficulties.

4. MEDICAL INFORMATION AND RECORDS. All laws concerning your access to medical records and copies of medical records apply to telehealth. Release of any images or information obtained during the telehealth session will not occur without your consent.

5. CONFIDENTIALITY. All confidentiality protections under federal and state law apply during your telehealth consultation. Healthcare information may be shared with other office staff for scheduling, billing and operating videoconferencing equipment. You will be informed of their presence and the office staff will maintain confidentiality of information obtained during the session time.

6. RIGHTS. You have the right to ask non-medical personnel to leave the telehealth examination room and/or terminate the consultation at any time.

My healthcare provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agreed to a telehealth consultation.

_____ _____

Signature of Patient or Patient's Representative Date of Signing

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Relationship of Representative to Patient