Telehealth Informed Consent Form

I _____(patient's name) hereby consent to engage in telehealth with _____ (provider's name) as part of my psychotherapy. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth may also involve the communication of my medical/mental information, both orally and visually, to health care practitioners.

I understand that I have the following rights with respect to telehealth:

1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction shall not occur without my written consent.

3) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures.

4) I understand that if I am in need of emergency mental health services, I should contact my local emergency room.

5) I understand that I have a right to access my medical information and copies of medical records in accordance with the law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____ _____

Signature of patient/parent/guardian/conservator Date

If signed by other than patient, indicate relationship _____.

Print Name _____