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CONSENT TO PARTICIPATE IN TELEHEALTH CONSULTATION

Name:____ Date:____________________

1. PURPOSE. The purpose of this form is to obtain your consent for a telehealth consultation with a therapist. The purpose of this consultation is to assist in the treatment of:____

2. NATURE OF TELEHEALTH CONSULTATION. Telehealth involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical/therapy information for the purpose of therapy, follow-up and/or education. During your telehealth consultation, details of your treatment history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunication technology.

3. RISKS, BENEFITS AND ALTERNATIVES. The benefits of telehealth include having access to mental health therapists and additional information and education without having to travel outside of your local health care community. A potential risk of telehealth is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telehealth appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telehealth consultation is a face-to-face visit with a therapist.

4. TEACHING, RESEARCH AND HEALTHCARE INSTITUTION. A Place To Turn, Inc. is a supervisory center. Associates may participate in telehealth consultations, under the supervision of attending therapist, as part of your treatment. Additionally, non-medical technical personnel may participate in telehealth consultation to aid in the audio/video link with the therapist.

5. MEDICAL INFORMATION AND RECORDS. All laws concerning patient access to medical records and copies of medical records apply to telehealth. Dissemination of any patient indentifiable images or information from the telehealth consultation to researchers or other entities shall not occur without your consent.

6. CONFIDENTIALITY. All existing confidentiality protections under federal and California law apply to information used or disclosed during your telehealth consultation.

7. RIGHTS. You may withhold or withdraw your consent to a telehealth consultation at any time before and/or during the consult without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

My therapist/Associate 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 Client or Client's Representative Date of Signing

____________________________________ ________________________
Relationship of Representative to Client Name of Interpreter/ID #

____
Signature of Witness (required if client unable to sign)

REFUSAL: I refuse to participate in a telehealth consultation as described above.

Signature: ____ Date: ____________