Telehealth Consent Form

Patient's Name:	Location of Patient:

Introduction:

Telehealth involves the use of electronic audio-video communication equipment to enable remote contact with health care professionals. The purpose of telehealth is to improve patient care by providing timely and confidential access to clinicians.

Telehealth may be used to facilitate behavioral assessment and/or the delivery of direct therapeutic services such as: behavior consultation, parent training, program support and/or other behavioral services.

Expected Benefits:

Telehealth allows for several enhancements to therapeutic service, including:

- Improved access to healthcare
- More efficient evaluation and case management
- Reductions in transportation time
- Overall reductions in healthcare costs

Potential Risks:

Any electronic transmission of personal health information comes with potential risks. These risks may include, but are not limited to:

- Poor audio/video resolution or temporary connectivity outages.
- Delays in treatment due to deficiencies or failure of telehealth equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information

Please note that the clinician will take every precaution possible to maintain the safety and confidentiality of their clients. Also, clients may withdraw from or refuse treatment via telehealth **at any time or for any reason** without risk of penalty or loss of service.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy of medical information also apply to telehealth and the no information obtained in the use of telehealth which identifies me will be disclosed to other entities without explicit consent.

2. I understand that I have the right to withhold or withdraw my consent for the use of telehealth without risk of penalty or loss of service.
3. I understand that my clinician has the right to terminate telehealth care if she determines the practice to present a risk to the client's health or if confidentiality cannot be adequately protected.
4. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

I, the undersigned, hereby authorize that I have read, understood and agree to use telehealth as a part of my treatment or in the treatment of my legal dependent.

_____ _____

Signature of Patient or Authorized Guardian Date

If authorized signer, relationship to patient: _____