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Telemental Health Informed Consent

I, _____ (name of client and DOB) hereby consent to participate in telemental health with _____ (name of provider) as part of my therapy. I understand that telemental health is the practice of delivering clinical healthcare services via technology assisted media or other electronic means between a provider and a client who are in two different locations.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services or program benefits to which I would otherwise be entitled.
2. I understand that there are risks and consequences associated with telemental health, including but not limited to interruption to transmission by technology failures, and/or possible breaches of confidentiality by unauthorized persons, and/or limited abilioty to respond to emergencies.
3. I understand that there will be no recording of the online activities by either party. All information disclosed within sessions and written records pertaining to these sessions are confidential and may not be disclosed to anyone without written authorization except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also extend to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder or vulnerable adult abuse, danger to self or others, or if I raise the issue of emotional/mental health as an issue in a legal proceeding).

5. I understand that, if I am having suicidal thoughts, actively experiencing psychotic symptoms, or am experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health is not appropriate and that a higher level of care is required.

6. I understand that, during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we ae unable to reconnect within ten minutes, your provider will call you to discuss, and possibly re-schedule.

7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in the case of an emergency.

Emergency Protocols

Your therapist needs to know your location in case of an emergency. You are agreeing to provide the physical address of the location where you are at the start of each session. You are also agreeing to provide the name of a person who could be contacted in the case of a life-threatening emergency only. This person would only be contacted to go to your location or take you to a hospital in the event of an emergency.

In case of an emergency, my location is _____,

and my contact person's name, address and phone number is

_____.

I have read the information provided above and have discussed it with my therapist. I understand the information contained in this form, and all of my questions have been answered to my satisfaction.

_____ _____

(signature of client/parent/legal guardian) (date)

_____ _____

(signature of therapist) (date)