Telehealth Consent

R10/20/20

Purpose

The purpose of this form is to obtain your consent to participate in Telehealth for behavioral health and medical services you receive from the agencies of Community Health Alliance, Sojourner Recovery Services and Transitional Living.

Use of Telehealth

Telehealth may be used to provide behavioral health or medical services to you in circumstances when it is not possible to meet in your home, the community or the office or based on your personal preference. Telehealth is utilized to ensure patients have adequate access to healthcare providers and allows you to stay connected to your health care provider.

Use of Technology

Telehealth may occur via electronic videoconferencing such as Facetime, Zoom, WebEx and other electronic mediums. Patients shall have choices in what type of electronic videoconferencing they wish to use based on availability. Your health care information may be shared with other persons essential to the scheduling, billing or operations of providing telehealth services. At times during telehealth sessions, there may be others present to assist with the functioning of the equipment. Protected health information will remain confidential. You will be notified in the event others are needed to be present for the visit. You have the right to ask others present to leave the room or terminate the visit at any time.

Confidentiality

Reasonable and appropriate measures will be taken to protect the confidentiality of protected health information and eliminate confidentiality risks associated with telehealth visits. All existing confidentiality protections under the law will apply to information exchanged during telehealth visits.

Risk and Consequences

There are some potential risks of using technology, including interruptions, unauthorized access and technical difficulties. You or your healthcare provider may decide to discontinue the visit if it is felt that the videoconferencing connections or privacy are not adequate for the visit. Some circumstances may require a follow-up in-person visit.

Rights

You may withhold or withdrawal consent to telehealth visits at any time. You have the option to consult with a healthcare provider in-person.

Acknowledgement and Consent

I understand all the potential risks consequences and benefits of telehealth and understand the information provided in this consent. I will ask questions of my healthcare provider if questions arise during the course of my treatment/services.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

Staff Signature: _____ Date: _____