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### **Telehealth Services Informed Consent**

Telehealth involves the use of electronic communications to enable professionals to connect with individuals **using interactive video and audio** Communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. **NO PHONE CALLS ACCEPTED- MUST HAVE VIDEO CAPABILITIES**

I understand that I have the rights with respect to telehealth

1. I understand privacy and the confidentiality laws apply to telehealth, and that no information obtained through the, use of telehealth services-will be disclosed to researchers or other entities without my written consent.
2. My healthcare provider has explained how the videoconferencing technology will be used to conduct a telehealth session, that Unlike direct patient/provider in person, I will not be in the Same room as my health care provider.
3. I understand the potential risks to technology including. interruptions, unauthorized access and technical difficulties. I understand my health care provider or I can discontinue the video conference consult is believed videoconferencing technologies are not adequate for the situation.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
5. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I agree certain situations such as emergencies and crisis are inappropriate for audio/yideo-/computer based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented healthcare facility in my immediate area.

### **Consent to The Use of Telehealth**

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 ample to ask questions and that any questions have been answered to my satisfaction.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_