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Telehealth Disclosure

Telementalhealth (TMH) Informed Consent

I _____hereby consent to engage in telementalhealth therapy (includes synchronous and asynchronous forms of communication). I understand that telehealth includes the practice of health care including mental health delivery, diagnosis, consultation, treatment and education using HIPPA compliant interactive audio and video.

I Understand that I have the Following rights with respect to Telementalhealth:

1. 1. I have the right to refuse TMH at any time without affecting my right to future care or treatment.

2. 2. The laws that protect the confidentiality of my medical information also apply to telehealth and that the information disclosed by me in therapy is confidential with exception of the mandatory reporting laws that include but are not limited to: child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim, imminent risk of harm to myself, and where I make my mental or emotional state an issue in a legal proceeding. (Refer to the Office Policies and HIPPA notice of Privacy Practice forms provided to you for more details of confidentiality and other practice procedures)

3. 3. I understand that the dissemination of any personally identifiable images or information from our telehealth interaction shall not occur without my written consent.

4. 4. I understand that TMH sessions are not being recorded, and separate

written approval and consent is needed in order to videotape a session

5. 5. I understand that there are risks from TMH that may include but are not limited to: the possibility despite all reasonable efforts by my provider, the transmission of medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings may occur more easily, particularly when care is delivered in an asynchronous manner.

6. 6. I also understand that while there is an empirical evidence base supporting the efficacy of TMH, it may not yield the same results as face to face services. I understand that if my provider believes that I would be better served by another form of therapeutic service (such as face to face) I will be referred to a therapist in my area who can provide such a service.

7. 7. I understand that my contact information and contact information for my emergency contact will be available at every session and give consent to contact my emergency contact if deemed necessary.

8. 8. I understand that in the event of technical failure, I will provide a phone number for follow up contact if a plan for technical failures has not already been arranged with my provider.

9. 9. I understand that any form of psychotherapeutic service carries risks and benefits and that despite my efforts and my providers efforts, my condition may not improve and in some cases may worsen.

10. 10. I understand that results from telemental health cannot be guaranteed or assured. The benefits of telehealth may include but are not limited to: increased ability to express thoughts and feelings, transportation and travel barriers are reduced, and time constraints are minimized which may offer a greater opportunity to prepare for sessions in advance and may lead to fewer cancellations.

11. 11. I understand that I have access to my medical information and copies of medical records in accordance with MA laws. I understand that these services may not be covered by insurance and that I may be res/Users/sherylknopf/Documents/Telehealth Releaseponsible for any fees incurred during psychotherapy which incorporates TMH.

I understand that I may revoke this authorization at any time by giving my written

notice. I may specify the date, event or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

Name_____ Date_____

Signature_____