

CREATE! Informed Consent for Telehealth Services

PATIENT NAME: _____
LOCATION OF PATIENT: _____
DATE OF BIRTH: _____
DATE CONSENT DISCUSSED: _____

Introduction:

Telehealth involves the use of electronic communications to hold live two-way audio and video sessions. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of the video session. Video platforms do not record the video and are HIPAA compliant.

Expected Benefits:

Improved access to mental health care by enabling continuity of care when in-office sessions are not possible.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate counseling
- Delays in treatment could occur due to deficiencies or failures of the equipment
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information

By signing this form, I understand the following:

- I understand that the laws that protect privacy and the confidentiality of mental health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to other entities without my consent.
- 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.
- I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.
- 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.

Patient Consent To The Use of Telehealth:

I have read and understand the information provided above regarding telehealth, have discussed it with my clinician and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care.

I hereby authorize C.R.E.A.T.E! to use telehealth:

Signature of Patient (or person authorized to sign for patient): _____ Date: _____

I have been offered a copy of this consent form (patient's initials) _____

If authorized signer, relationship to patient: _____

Witness: _____ Date: _____