SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

TELEHEALTH INFORMED CONSENT FORM

CLIENT INFORMATION	
Client Name:	**DOB:**
MR#	
Telehealth Provider:	Program:
☐ This provider has reviewed and updated the client's current address, phone number, and emergency contacts.	

INTRODUCTION

You are going to have a clinical encounter using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. The information may be used for diagnosis, treatment, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a client to remain at a remote location and obtain services from providers at distant sites.
- Client remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the client or other provider.

The Process:

If you are not comfortable with seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional telephone session without video at any time. Safety measures are being used to ensure that this videoconference is secure, and no part of the encounter will be recorded without your consent.

Possible Risks:

There are potential risks associated with the use of telehealth which include, but may not be limited to:

- A provider may determine that the telehealth encounter does not provide sufficient information to make an appropriate clinical decision, which may require additional in-person visits.
- Technology problems may delay medical evaluation and treatment at any time.
- In very rare instances, security protocols could fail, causing a breach of privacy of your information. You will be promptly notified if any security issues arise.

By Signing or Verbally Consenting to this Form, I understand the following:

1. I understand that I have the right to 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.
2. 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.
3. I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth.

Verbal Consent to the Use of Telehealth:

☐ This form was reviewed with the client. Client has verbally confirmed understanding the information provided above regarding telehealth, and all of the client's questions have been answered. **Date/Time of Verbal Consent:** _____

The client has authorized _____ to use telehealth in the course of the client's diagnosis and treatment.
(Agency Name)

Signature/Verbal Confirmation of Client(or authorized person)_____Date/Time _____

Signature of Provider Confirming that Informed Consent was Obtained_____Date/Time _____