HENRICO AREA MENTAL HEALTH & DEVELOPMENTAL SERVICES

Telehealth Informed Consent

Introduction

Telehealth is the form of healthcare care that uses audio-video conferencing tools to connect a healthcare provider and patient who are not at the same location.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient health information and will include measures to safeguard the data and to ensure its integrity and privacy against intentional or unintentional corruption and unauthorized access.

Expected Benefits:

Benefits of telehealth include improved access to behavioral healthcare by enabling a client to remain in his/her home or office and receive evaluation and treatment.

Possible Risks:

Potential risks associated with the use of this technology include interruptions, unauthorized access and technical difficulties.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that my telehealth sessions will not be recorded by me or my provider without both of us giving consent.
3. 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.
4. I understand that I have the right to inspect all information obtained in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.
5. I understand that a variety of alternative methods of care may be available to me, and that I may choose one or more of these at any time.
6. I understand that it is my duty to inform my provider of any other healthcare providers involved in my medical/psychiatric care.
7. 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.

Client Consent To The Use of Telehealth

I have read and understand the information provided above regarding the benefits and risks of telehealth. I have discussed the contents of this form with my provider or another as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my health care.

I hereby authorize _____at Henrico Area Mental Health & Developmental Services to use telehealth in the course of my diagnosis and treatment.

Signature of Client (or person authorized to sign for Client): _____ *Date:*_____

Printed Name of the Client: _____

*If authorized signer, relationship to patient:*_____

*Witness:*_____ *Date:*_____