



TELEHEALTH INFORMED CONSENT

I am agreeing that there may be certain circumstances in which the provision of my mental health services may be via telehealth.

I understand that the video and audio connections used for telehealth are secure and meet federal, state and agency privacy standards.

I understand that in the course of a telehealth session there may be technical problems which could result in the disruption of my session. Reasonable attempts will be made to remedy any disruptions. In the event that the session cannot continue due to technological problems, I will be offered an alternative appointment time.

I understand that my participation in telehealth is voluntary, and I may discontinue participating in services through telehealth at any time. In the event that I choose to discontinue my participation in telehealth, face to face services will be offered.

Print Name: _____

Client Signature: _____

Date: _____

Guardian's Print Name (If applicable): _____

Guardian Signature (If applicable): _____

Date: _____

FOR OFFICE USE ONLY:

Client Name: _____

MR #: _____

DOB: _____