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Telemedicine Informed Consent

I, _____, hereby consent to participate in Telemedicine. I understand that Telemedicine is the practice of delivering clinical health care services via technology assisted media between a practitioner and a client located in two different locations.

I understand the following with respect to Telemedicine:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with Telemedicine, including but not limited to disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information exchanged will be kept confidential by the provider and within the electronic health record (EMR).

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Telemedicine unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others.

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telemedicine services are not appropriate and a higher level of care is required.

6) I understand that during a Telemedicine appointment, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call the office at 239-939-9090. If we cannot resolve the issue, we will re-schedule the session.

7) I understand that my provider of services may have to call my emergency contact representative, and/or appropriate authorities in case of an emergency.

I have read the information provided above and discussed it with my provider. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of patient/legal representative Date