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Telemedicine Informed Consent

Name of Client (if this is for a child, please put child's name):

_____

I hereby consent to engaging in telemedicine as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical/mental health data, and education using interactive video, audio, or data communications. The rights stated supplement those rights I have generally as a patient.

I understand that I have the following rights with respect to telemedicine:

• I have the right to withhold or withdraw consent to telemedicine treatment at any time.

• The laws that protect the confidentiality of my medical/mental health information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards myself or an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

• I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures, the transmission of my medical information could be interrupted by unauthorized persons, and the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases may even get worse.

• I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

• As with all medical records, I understand that I have a right to access my medical information and copies of medical records of telemedicine treatment in accordance with New York State law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment.

_____ _____

Signature Date

[Parent or guardian's signature if client is under 18 years old]