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ETCH
EARLY TREATMENT & COGNITIVE HEALTH

Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable ETCH providers to connect with individuals using interactive video and/or audio communications.

I understand that telehealth services include, but are not limited to, the practice of psychological health care delivery, diagnosis, consultation, and treatment using interactive audio, video, or data communications.

I understand that I have the following rights with respect to telehealth services:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. The laws that protect the confidentiality of my medical information also apply to telehealth services. As such, I understand that the information disclosed by me during 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 an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

3. I also understand that the dissemination of any personally identifiable images or information from the telehealth services to researchers or other entities shall not occur without my written consent.

4. I understand that there are risks and consequences from these services, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider 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/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. In addition, I understand that telehealth services may not be as complete as face-to-face services. I also understand that if the provider believes I would be better served by another form of therapy/psychiatry services (e.g. face-to-face services) I may be referred to a provider who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of therapy/psychiatric services, and that despite my efforts and the efforts of the provider, my condition may not be improve, and in some cases may even get worse.

6. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured.

By signing below, I consent to engaged in telehealth services with the license provider I have selected through ETCH. I have read and understand the information provided above.

Printed Name	**Signature**	**Date**

Witness Printed Name	**Signature**	**Date**