CCMHS - INFORMED CONSENT FOR TELEHEALTH SERVICES

Consumer Name:		Date of Birth:		Medical Record:
Consumer Address:	City:	State:	Zip:	Date Consent Discussed:
Provider Name:				

INTRODUCTION

Telehealth involves the use of electronic communications to enable health care providers at different locations to connect with individuals using interactive video and/or audio communications. This may include the use of telephone/smart phones, personal computers, laptops, or tablets with video technology that meets HIPAA standards. Electronic systems used by the provider will incorporate network and software security protocols to protect the confidentiality and privacy of consumer information.

Services available through Telehealth are outlined in the Michigan Department of Health and Human Services Telehealth Encounter Code Chart.

POSSIBLE RISKS

While using telemedicine, your medical information will be handled with strict confidentiality, privacy and security; however, you should know there are risks associated with any communication technology.
These risks include, but may not be limited to:

- Technical difficulties; possibility of a technical support staff needing to assist
- Unauthorized access by others at your location; someone could overhear you or see you if you are not in a private area
- The security of your session could be at risk if your smart phone, computer, and/or internet service provider is not configured property or has malware
- In very rare instances, security protocols could fail, causing information in the communication channel to be accessed by a third party

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of my health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed, except as allowed by law, without my consent,
2. I understand that in many cases the preferred method of service delivery is face-to-face and that my provider will use their judgement and discuss any recommendations for services to be face-to-face at any time during my care.
3. I understand that my provider will ask me for two pieces of identifying information such as date of birth and last four number of my Social Security Number at the beginning of each session to ensure I am who I say I am.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained.

I further understand that I will be informed of their presence and thus will have the right to request the following: (1) omit specific details of my clinical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the service at any time.

5. I understand that receiving services through telehealth is voluntary and 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.
6. I understand that a variety of alternative methods for service delivery may be available to me, and that I may choose one or more of these at any time. _____ (*Name of Provider*) has explained the alternatives to my satisfaction,

Consumer CONSENT TO THE USE OF TELEHEALTH

I have read, or have had the information read to me, and understand the information provided above regarding telehealth, have discussed it with my mental health and/or substance use disorder provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my mental health and/or substance use disorder services.

I hereby authorize _____ (*name of Provider*) to use telehealth in the course of my treatment.

Consumer's SIGNATURE	**DATE**
(OR AUTHORIZED PERSON TO SIGN FOR Consumer)	
IF AUTHORIZED SIGNER, RELATIONSHIP TO Consumer	
WITNESS	**DATE**
Provider's SIGNATURE	**DATE**

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IF CONSENT IS SECURED VERBALLY: (Must secure signature above as soon as possible.)

This consent was originally provided verbally by _____ [Consumer Name]
To _____ [Provider Name] on _____ [Date].

Provider Signature _____

I have been offered a copy of this consent form. _____ (Consumer's Initials)