Consent for Telehealth Services

(Service delivered in the home or community)

I agree to voluntarily receive clinical telehealth treatment provided by Solano County Mental Health. The technology that we are using is secure. Electronic systems used will incorporate network and software protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

When utilizing telehealth services, it is expected that both the provider and you:

- Are in a private space to not be overheard and to maintain confidentiality
- Do not record or capture any part of the telehealth meeting (audio or visual)
- Do not make or accept any other communication on your phone during the telehealth meeting (e.g. phone calls, texts, emails, social media)

Benefits

- Use the services in the comfort of your own home
- Elimination of transportation needs
- Reducing risk of coming into contact with others who may be sick
- Convenience to access mental health services
- Access to a variety of different types of providers

Risks

- If there is a poor internet or program connection, it may be more difficult for the provider to understand or assess what is going on during the meeting
- Delays in treatment or evaluation due to deficiencies or failures of the equipment
- In rare instances, security protocols could fail, causing a breach of privacy of personal health information

By my verbal consent and/or signing this form, I understand and agree to the following:

1. I will let the provider know my location at the beginning of the telehealth meeting.
2. I understand that the laws that protect privacy and the confidentially of personal health information also apply to telehealth, and that information obtained in the use of telehealth will not be disclosed without my consent. This does not include already reviewed exceptions to confidentiality (e.g. danger to self or others, suspected abuse).
3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my treatment at any time, without affecting my right to future care or treatment.
4. I understand that a variety of alternative methods of mental health and/or psychiatric care may be available to me, and that I may choose one or more of these at any time.
5. I understand that I may expect the anticipated benefits from the use of telehealth in my treatment, but that no results can be guaranteed or assured.

Print Client Name	Date of Birth
Client Signature	Date
Signature of Authorized Representative	Date

☐ **Client refuses or is unable to sign but verbally agreed to receive Telehealth Services on the following date:** _____ Staff Initials _____ Date

SOLANO COUNTY MENTAL HEALTH DIVISION **CONSENT FOR TELEHEALTH** ***Confidential Patient Information*** See California Welfare and Institutions Code Section 5328 and Health Information Portability and Accountability Act Privacy and Security Rules Page 1 of 1	**CLIENT NAME:** **MEDICAL RECORD #:**

Revised March 2020