Luisa Contreras Family Therapy, Inc.

Informed Consent for Telemedicine Services

Name ______________________________ _________________________ _______________________
First Middle Last

Age_______ Date of Birth ___ / ___ / ___ Female ___ Male ___ Other ____

Location ____

Phone #____

Therapist Name ____

Location ____

Licensed Clinician/Supervisor's Name____

Location ____

Date and Time Consent Discussed _________________________________

Introduction: Telemedicine involves the use of electronic interaction and communication to enable mental health care providers service population outside their local area for the purpose of improving client's mental health.

The information may be used for diagnosis, therapy, follow-up and/or education, may include any of the following: Client medical records. Live two-way audio and video. Output data from medical devices and sound and video files Electronic. Systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.
Expected Benefits: Obtaining expertise of a distant Mental Provider.

Risks: As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include but may not be limited to: These risks include but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g poor resolution of images, voice) to allow for appropriate medical decision making by the provider. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment in very rare instances security protocols could fail, causing a breach of privacy of personal medical information.

Intials______

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative me methods of medical care may be available to me, and that I may choose one more of these at any at any time.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
6. I understand that it is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding telemedicine, have discussed it with my mental health provider, clinician (or assistant) as may be designated, and all of my questions have been answered to my satisfaction.
I hereby authorize

____ (name of therapist) to use

telemedicine in the course of my diagnosis and treatment.

Signature of Client (or person authorized to sign for client): ____________________________________

I hereby give my informed consent for the use of telemedicine in my mental health treatment.

Date: ____

If authorized signer, relationship to client: ____

Therapist: ____

Date: ____

I have been offered a copy of this consent form (initials) _________