

## **Informed Consent for Telehealth Treatment**

Preferred name: \_\_\_\_\_  
First Last

Name in medical record (if different): \_\_\_\_\_  
First Last

Date of birth (MM/DD/YYYY): \_\_\_\_\_  
date of birth (month/day/year)

Please note that ongoing telehealth treatment with a California-licensed mental health provider may not be available at this time if you are physically located outside of the state of California. At the start of your visit, your provider will ask you for the address where you are receiving telehealth services in order to confirm that you are located in California or in another location where such services are currently available and to ensure there is an accurate location for you in case of an emergency.

If a telehealth visit does not work for you for any reason, please let your provider know and alternative support options can be considered.

Prior to your telehealth visit, please read the below consent for telehealth treatment.

1. You retain the option to withhold or withdraw consent at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. The laws that protect the confidentiality of your medical information also apply to telehealth. The information disclosed by you during the course of your treatment is generally confidential. Exceptions to confidentiality laws include the requirements to: protect you or the public from serious harm; report abuse or neglect of children, the elderly, or people with disabilities; and respond to an order from a court or other valid legal process such as a subpoena.
3. Your provider uses an electronic platform for healthcare that meets HIPAA requirements that are needed to secure patient health information (PHI). This electronic platform encrypts all audio, video, and screen sharing data as a means of protecting your personally identifiable information. Despite these efforts there are risks associated with telehealth. These may include, but are not limited to, the possibility that transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your medical information could be interrupted by unauthorized persons; and/or misunderstandings between you

and your provider can more easily occur. In addition, telehealth-based services and care may not yield the same results or be as effective as face-to-face service. If you or your provider believes you would be better served by face-to-face service, you may be referred to a provider in your area to receive such service. Finally, there are potential risks associated with any form of mental health treatment, and despite your efforts and the efforts of your provider, your condition may not improve, and in some cases may even get worse.

4. The benefits of telehealth may include removing transportation and travel barriers, minimizing time constraints, and providing greater opportunity to prepare in advance for treatment sessions.

5. All existing laws regarding access to your medical information and copies of medical records apply.

6. You agree not to record or share the content of your telehealth visit. You agree to conduct the visit in a private space without any other attendees present, or able to hear or see your visit, unless an alternative arrangement is agreed to by you and your provider. If someone comes into the room during your visit, please pause your video and restart only after they have left.

The parties acknowledge and agree that this informed consent for telehealth treatment may be executed by electronic or digital signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

**Please sign below to acknowledge that you have reviewed this document and give your consent:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
today's date (month/day/year)