**Child & Adolescent/Adult Behavioral Health Clinics**
**Informed Consent for Telehealth Consultations**

Health care services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as "telemedicine" or "telehealth,", this means that I may be evaluated and treated by a health care provider or specialist from a different location. Since this is different than the type of consultation with which I am familiar**, I understand and agree to the following:**

1. The consulting health care provider or specialist will be at a different location from me. A physician or other health care provider ("presenting practitioner")will be at my location with me to assist in the consultation.
2. The presenting practitioner may transmit or share electronically details of my medical history, examinations, x-rays, tests, photographs or other images with the specialist who is at a different location.
3. Details of my medical history, examinations, medications, x-rays, and tests will be discussed with the specialist who is at a different location.
4. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the consultant and presenting practitioner. I will give my verbal permission prior to additional personnel being present.
5. Video recordings may be taken of the telehealth consultation, after I have given my written permission prior to recording. Video recordings and other data, including x-rays, images, and photos may be kept, viewed, and used for purposes including teaching, training, technical, scientific, research, or administrative purposes.
6. The physician or health care provider for whom the on-site examination or treatment is performed will keep a record of the consultation in my medical record.

Noting all the above, I understand that my participation in the process described (called "telemedicine" or "telehealth") is voluntary and constitutes a waiver of the usual right to physician-patient privacy and may possibly increase the risk of disclosure of my medical data.

**I further understand that I have the right to:**

1. Refuse the telehealth consultation, or stop participation in the telehealth consultation at any time.
2. Limit any physical examination proposed during the telehealth consultation.
3. Request that the presenting practitioner refrain from transmitting my information if I make the request before the information is transmitted.
4. Request that nonmedical personnel leave the room(s) at any time.
5. Request that all personnel leave the room(s) to allow a private consultation with the off-site specialist(s).

I acknowledge that the health care providers involved have explained the consultations in a satisfactory manner and that all questions that I have asked about the consultations have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

Patient:_____ Date:_____
*(please sign)*

Patient Representative:_____Date:_____

Witness:_____Date:_____

Patient name:_____

Provider :_____

Location:_____

**Please FAX signed form to xxx-xxx-xxxx and place original in patient's record.**