



Carbon-Monroe-Pike Mental Health and Developmental Services

Tina L. Clymer, MS, LPC, Administrator

INFORMED CONSENT TO TELEHEALTH

Due to the COVID-19 Crisis, all services through Carbon-Monroe-Pike Mental Health and Developmental Services are being provided using a Telehealth model. Telehealth allows staff to interact with me using interactive audio, video, or data communication.

Name of person agreeing to Telehealth: _____

Name of MH/DS staff person witnessing agreement: _____

Date of Consent: _____

MH/DS Staff person will place initials by each statement agreed to by the individual being served or their guardian.

_____ I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my protected information during face-to-face sessions. Any information disclosed by me during the course of my Telehealth interaction is generally confidential. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

_____ I understand that there are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, MH/DS staff has the right to break confidentiality to prevent the threatened danger

_____ I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our sessions or other communication to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. I understand that when using third party applications such as Zoom, GoToMeeting, Skype, other video platforms, there are potential privacy risks.

_____ I understand the information provided above. I have the right to discuss any of this information with MH/DS staff and to have any questions I may have regarding my treatment answered to my satisfaction.

_____ I consent to the use telephone communication.

_____ I consent to the use of video communication.

_____ I understand that I can withdraw my consent to Telehealth communications by providing written or verbal notification. My signature below indicates that I have read this Agreement and agree to its terms.

_____ I understand that verbal consent witnessed by Mental Health and Developmental Service Staff will be used for my consent until such a time when face-to-face interaction is safe and permissible. As soon as possible following the COVID-19 Crisis, written consent will be obtained.

To be signed **in-person following the crisis:**

Signature of person who consented to Telehealth: _____ Date: _____

Witness of in-person signature: _____ Date: _____