Telehealth Informed Consent

I, _____, hereby consent to participate in Recovery Ways Idaho telehealth services as part of my behavioral health treatment. I understand that telehealth services are the practice of delivering clinical health care services via technology such as video chat or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to telehealth services:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2. I understand that there are risks, benefits, and consequences associated with telehealth services, including but not limited to disruption of transmission by technology failures, and/or limited ability to respond to emergencies.

3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth services unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse, danger to self or others).

5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.

6. I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, I will call you to continue the session via telephone or to reschedule the appointment. Please be advised that I may be calling with a blocked number. Please accept the call.

7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

I have read the information provided above. I understand the information contained in this form. I understand that I may ask my service provider to clarify any additional questions I may have.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Witness Date