TELEHEALTH INFORMED CONSENT

I am agreeing that there may be certain circumstances in which the provision of my mental health services may be via telehealth.

I understand that the video and audio connections used for telehealth are secure and meet federal, state and agency privacy standards.

I understand that in the course of a telehealth session there may be technical problems which could result in the disruption of my session. Reasonable attempts will be made to remedy any disruptions. In the event that the session cannot continue due to technological problems, I will be offered an alternative appointment time.

I understand that my participation in telehealth is voluntary, and I may discontinue participating in services through telehealth at any time. In the event that I choose to discontinue my participation in telehealth, face to face services will be offered.

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Print Name

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Signature of Client

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Date

____
Guardian's Print Name (If applicable)

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Signature of Guardian (If applicable)

____
Date

2/27/18, 10/2025

Client Name:____________________
Client DOB:_____________________
MR# : _________________________