

## Informed Consent to Participate in Telemedicine Services and Videotape

I, \_\_\_\_\_, have been asked to receive behavioral health services via telemedicine. I have been informed of my diagnosis and proposed telemedicine treatment plan. I understand that I will be receiving health care services through interactive videoconferencing equipment. I understand that, at this time, there are no known risks involved with receiving my care in this way.

I understand that the equipment will be shown to me and I will see how it works before I receive any services. I understand that my participation in telemedicine is voluntary and I may refuse to participate or decide to stop participation at any time. I understand that my refusal to participate or decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of my revocation of informed consent to treatment.

I understand that my privacy and confidentiality will be protected. I also understand that the likelihood of a videoconference being intercepted by an outsider is similar to the potential interception of a phone call. When I am receiving services via telemedicine, I will be notified as to who is in the room at the remote site.

I understand that the services I receive via telemedicine can be videotaped and viewed by other persons for a specific clinical or educational purpose. I understand that I have the right to rescind permission to use the videotape at any time. I understand that the use of the videotape recording is for the following purpose: \_\_\_\_\_

I understand that the health care providers at both my location and the remote video site will have access to any relevant medical information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records.

I have read this document and I hereby consent to participate in receiving behavioral health services via telemedicine under the terms described above. I understand this document will become a part of my medical record.

**Please check the appropriate box below.**

I agree to participate in and receive behavioral health services via telemedicine. I understand that these clinical sessions will be videotaped. I understand that the permission I grant here to use the videotape will become void on \_\_\_\_\_ (date) unless I renew the permission in writing at that time.

I have chosen not to participate in telemedicine sessions.

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

**PM FORM 3.11.2**

The above release is given on behalf of \_\_\_\_\_ because the member is a minor or has been determined to be incompetent to give medical consent.

\_\_\_\_\_  
Parent, Legal Guardian, or Government Agency  
Authorized by the Court (Copy of Court Order Attached)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Witness