OAK BROOK BEHAVIORAL HEALTH

TELEHEALTH CONSENT FORM

(REQUIRED IN THE EVENT TELEHEALTH IS NECESSARY)

I,_____, hereby consent to engage in telehealth. Telehealth is a form of psychiatric and/or psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I understand that telehealth involves the communication of my medical/mental health information, both orally and/or visually.

Telehealth has the same purpose or intention as treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that telehealth may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. Nobody will record the session without the permission from the others person(s). However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment.

2. I understand that there are risks and consequences of participating in telehealth, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

3. I agree to use the video-conferencing platform selected for our virtual sessions, and the provider will explain how to use it. I need to use a webcam or smartphone during the session. I am responsible for providing the necessary computer, telecommunications equipment and internet access for my telehealth sessions. It is important to use a secure internet connection rather than public/free Wi-Fi.

4. I accept that telehealth does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

5. It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in telehealth. I am responsible for arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth session.

6. It is important to be on time. If I need to cancel or change your tele-appointment, I will notify the provider in advance by phone or email.

7. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to other entities shall not occur without my written consent.

8. The provider may determine that due to certain circumstances, telehealth is no longer appropriate and that sessions should resume in-person at the provider's office.

9. I, the client, have the right to withhold or withdraw consent to telehealth at any time without affecting my right to future care or treatment.

I have read, understand and agree to the information provided above regarding telehealth:

_____ _____

Patient's Signature Date

_____ _____

Parent's/Guardian's Signature (if Patient is a minor) Date