3/15/20. TELEMENTAL HEALTH CONSENT FORM

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TELEMENTAL HEALTH INFORMED CONSENT FORM

I _____ [name of patient(s)] hereby consent to engaging in telemental health with SUZANNE M ELTON LPC , LMHC (License OR1980 WA00011152) as part of my counseling. I understand that "telemental health" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of mental health data, and education using interactive audio, video, or data communications. I understand that telemental health also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in OREGON AND WASHINGTON. I understand that I have the following rights with respect to telemental health: (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. (2) The laws that protect the confidentiality of my medical and mental health information also apply to telemental health. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards self and/or an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. In case of emergency my location is:

_____ and
contact information for local emergency services is:

_____

I understand my therapist may contact my emergency contact and/or appropriate authorities in case of emergency. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction to researchers or other entities shall not occur without my written consent. (3) I understand that there are risks and consequences from telemental health, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health information could be interrupted by unauthorized persons; the electronic storage of my

medical information could be accessed by unauthorized persons; and/or limited ability to respond to emergencies. To accommodate possible interruptions of a counseling session, please have ready access to your cell phone or landline. The best telephone number for your counselor to call is _____. In addition, I understand that telemental health -based services and care may not be as complete as face-to-face services. I also understand that if my counselor believes I would be better served by another form of counselor services (e.g. face-to-face services) I will be asked to attend in-office sessions or be referred to a counselor who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of counseling, and despite my best efforts and the efforts of my counselor, my condition may take longer than expected to see improvement.

4). I understand that I may benefit from telemental health, but that results cannot be guaranteed or assured.

5). I understand that I have a right to access my medical and mental health information and copies of medical records in accordance with Oregon law.

I have read and understand the information provided above. I have discussed it with my counselor. And all my questions have been answered to my satisfaction.

Signature of patient/parent/guardian_____ Date _____
Indicate relationship if signed by someone other than client _____

Signature of Suzanne M Elton, LPC _____ Date _____