SMOKEY POINT
BEHAVIORAL HOSPITAL

INFORMED CONSENT FOR GROUP SESSION TELEHEALTH

Client Name:	**DOB:**	**Date:**
Site Where Client is Seen Via Telehealth:		
Consulting Provider Name seeing client via Telehealth:		
Provider Location:		

Introduction:

You are going to have clinical sessions using videoconferencing technology which includes live audio and video. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. The information may be used for therapy, follow-up or education. Other patients may be in the session at the same time to receive the benefits of group therapy.

Expected Benefits:

- Improved access to care by enabling you to remain within the facility and obtain services from providers at distant sites, or to remain at home if you are receiving outpatient services.
- Ability for you to participate in beneficial group counseling sessions.
- Ability for you to continue to receive care at your facility or home.
- Reduced need for you or the provider to travel.

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. You are required to participate in the telehealth session in a private room with no other participants. You may ask questions of the provider or any telehealth staff in the room with you if you are unsure of what is happening. If you are uncomfortable seeing a provider on telehealth or sharing your view with others, you may reject the use of technology for a group session and schedule a traditional face-to-face encounter at any time. Safety measures have been implemented to ensure that this videoconference is secure between the participants of the session and no part of the encounter will be recorded.

Please be advised that telehealth sessions must maintain applicable privacy and security requirements, including but not limited to compliance with HIPAA and under no circumstance are you to record any visual or auditory parts of the telehealth session, or discuss the session with anyone other than your provider. If a violation occurs you will be legally liable for the breach of confidentiality.

Possible Risks:

There are potential risks associated with the use of telehealth group sessions which include, but may not be limited to:

- A provider may determine that the telehealth encounter is not yielding sufficient information to make an appropriate clinical decision.
- Although rare, technology problems may delay medical evaluation and treatment for an encounter. Technology problems will be corrected as soon as possible.
- All participants will be advised of the confidentiality requirements and all participants will be required to also sign this form. A violation of confidentiality could occur by other participants in the

group session.
- Security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers, other persons who are not part of the session, or other entities without my consent.
2. I understand that the laws that protect privacy and confidentiality prevent me from recording, transcribing, or sharing any information in any way about participants in the teleconference sessions.
3. I understand that I have the right to withdraw my consent to the use of telehealth in the course of the session at any time, without affecting my right to future care or treatment.
4. I also understand that if the provider believes I would be better served by a traditional face-to-face encounter, the provider may, at any time stop the telehealth session and schedule a face-to-face visit and I will cooperate with the provider's request at any time.
5. I understand that cooperation of all participants in the session is required and I will be cooperative and follow the direction of the provider at all time.

Client consent to the use of Telehealth:

I have read and understand the information provided above regarding telehealth and have asked any questions I have, and all of my questions have been answered to my satisfaction. I understand the above and hereby give my informed consent for the use of telehealth in my care.

I hereby authorize_____to use telehealth in the course of my treatment.
(Hospital Name)

Signature of Client (or legally authorized representative) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _

If legally authorized representative, relationship to client _

Witness _ Date: _ _ _ _ _