Consent for Telehealth- All Programs

Client Full Name (Including First, Middle, Last)**:**	
Client DOB:	**Client ID:**

Overview.
Central Minnesota Mental Health Center (CMMHC) offers tele-mental health (telehealth) services using an CMMHC approved, HIPAA-compliant, telepresence video conferencing or telephone platform. These services comply with Minnesota State Statutes and Center for Medicare and Medicaid Services (CMS) guidelines for telehealth services. The telehealth service model allows for the delivery of mental health services when there are barriers that prevent the client(s) and providers from meeting in the same physical location. Using CMMHC approved HIPAA-compliant video conferencing software, the provider and the client(s) communicate directly via their compatible electronic device (computer, tablet, phone) using both audio and visual signals. CMMHC offers telehealth services to clients who are determined to be appropriate for telehealth services; who have access to a compatible electronic device and high-speed internet connection; and who agree to download the video conferencing software chosen by CMMHC on their device.

1. **Purpose and Benefits**. The purpose and benefit of telehealth visits is to provide more timely access to Mental Health services. In addition to providing the clients convenience, timeliness to scheduling, and increased access to Mental Health services.

2. **Client Safety OR Crisis management and interventions.** Before engaging in telehealth services, we will develop an emergency response plan to address potential crisis situations that may arise during our telehealth work. In the case of a mental health emergency during a telehealth session, where a client is deemed at imminent risk of harming themselves or someone else, CMMHC staff will contact the client's local emergency services, crisis response team, and/ or 911

3. **Medical Information and Records.** All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth service. Additionally, dissemination of patient-identifiable images of or information from this telehealth interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws. Records requests will be processed in a timely manner through our Health Information Management (HIM) department. A valid Release of Information (ROI) will be required.

4. **Modality.** May be either a telephone call from your provider to a mobile phone or landline or use of HIPAA compliant video-conferencing platform. Either option, will allow for 2-way communication between the client and provider throughout the course of the visit. Videoconferencing will permit the client to see the provider during the visit, while telephone encounter will not. Messaging and data rates may apply and are the responsibility of the client to pay.

5. **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth service. All existing confidentiality protections under federal and Minnesota states law apply to information disclosed during the telehealth visit.

6. **Fees.** Fees are reviewed with you during your financial intake and Fee Schedule is posted.

7. **Risks and Consequences.** The telehealth service will be like a routine Mental Health office visit, except with interactive video technology or by telephone which will allow you to communicate with a provider at a distance. I understand that there are risks and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, privacy, and/or limited ability to respond to emergencies. We will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted.

8. **Rights.** You may withhold or withdraw consent to telehealth services at any time without affecting your right of future care or treatment or risking the less or withdrawal of any program benefits to which you would otherwise be entitled.

9. **Technical Difficulties.** I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call the provider's office to discuss since we may have to re-schedule.

10. **Appropriateness of Telehealth services.** It may be determined that telehealth services are no longer the most appropriate form of treatment for you. If this occurs, we will discuss other options such as in-person services with you.

11. **DISCLAIMER.** This authorization is valid until 9/1/2020

Authorization.

I have been advised of all the benefits, potential risks, and consequences of telehealth. I have had an opportunity to ask questions about this service and all my questions have been answered. I understand the written information provided above.

Client Name: _____

Client Signature: _____ **Date:** _____

I am signing as an authorized representative for the client, I am

☐ Parent of a Minor ☐ Court Appointed Guardian/ Conservator (Legal Paperwork Required)

Parent/Guardian Signature: _____ **Date:** _____