TELEHEALTH INFORMED CONSENT FORM

I ________________________ (name of the client/patient) hereby consent to engaging in telehealth with ACC staff, as part of my psychotherapy. I understand that “telehealth” (a/k/a online counseling) includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Alaska or outside of Alaska.

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

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or 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 information also apply to telehealth. 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. These include, but are not limited to, reporting child, elder, and dependent adult abuse, expressed threats of violence towards an ascertainable victim, and where I make my mental and emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers and other entities shall not occur without any written consent.

3. I understand that there are risks and consequences within telehealth. These include, but are not limited to, the possibilities that the transmission of my medical information could be disrupted or distorted by technical failure, the transmission of my medical information could be intercepted by unauthorized persons, and the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by other forms of psychotherapeutic services (e.g. face-to-face services) I will be given the opportunity to have face-to-face appointments with my psychotherapist. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and, in some cases, may get worse.

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

5. I understand that I have the right to access my personal information and copies of case notes.

6. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for telehealth psychotherapeutic services. If I am in a crisis or emergency, I will immediately call 911 or go to the nearest hospital or crisis facility. I understand that emergency situations may include having thoughts about harming myself or others, having uncontrolled psychotic symptoms, being in a life-threatening or emergency situation, and needing medical attention due to the abuse of drugs or alcohol. I acknowledge I have been told that if I am suicidal, I am to call 911, local county crisis agencies, or the National Suicide Hotline at 1-800-784-2433.
I have read and understand the information provided above. I have discussed these points with my psychotherapist, and all of my questions regarding the above matters have been answered to my satisfaction. My signature below indicates that I have read this Consent Form and agree to its terms.

__________________________
Print Name Date

__________________________
Signature of Patient/Client or Personal Representative Date

If signed by other than Patient/Client indicate relationship Date

__________________________
Signature of Psychotherapist Date