CONSENT FOR TELEHEALTH CONSULTATION

I, (name of patient, aged 14 or older and a resident of New Mexico) ______________________________, agree to participate in telemedicine (telehealth) evaluation, assessment, and/or psychotherapy sessions – as defined by NM Statute 61-6-6(K), 61-6-11.1. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a professional mental health counselor and/or clinical social worker involved in my medical or mental health care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small, but still a possibility.]

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a provider in person.

I understand that medical records of telemedicine services will be kept at ESCC, LLC exclusively, and will continue to exist only in paper form, i.e. no electronic medical record.

None of my medical information may be used for teaching, educational, marketing, research, or any non-clinical purposes.

Additionally:

1. Sessions will be provided through HIPPA compliant interactive audio and video conferencing methods. _______ (Client Initials)

2. My clinician will conduct my Tele-Health sessions in a quiet and private room. In order to protect my privacy, I understand that I should do the same as well. ______ (Client Initials)

3. No permanent voice or video recordings are kept of my Tele-Health sessions. _____ (Client Initials)

4. There are potential risks and consequences in regard to Tele-Health sessions, including but not limited to; the possibility of the transmission of my personal information being disrupted or distorted due to technical failures or being disrupted by unauthorized persons. _____ (Client Initials)

5. Tele- Health services and care may not be as complete or effective as face to face services, especially if there is poor audio or video connection. ______ (Client Initials)

6. If my clinician believes it is in my best interest to receive in person services in lieu of Tele-Health sessions, I will be referred to such person in my area. _______ (Client Initials)

7. The laws protect my confidential information extend to information provided via Tele-Health methods. As such, I understand that any information I provide in these sessions is also confidential. However, all of the mandatory reporting exceptions listed in my general Informed Consent for Treatment, apply to my Tele-Health sessions too. ______ (Client Initials)

8. The conditions outlined in this document are in addition to the conditions in my previously signed general Informed Consent for Treatment. _______ (Client Initials)

9. I have the right to withdraw my consent for Tele-Health services at any time. ______ (Client Initials)

Authorization of Consent

Signature of patient: _______________________________ Date: ______________
Please print the above name: ____
Printed name and signature of parent/guardian: ____
Date: ______________

____
Signature of ESCC Representative

Client's emergency Contact: ___________________________ Contact's Phone Number: _________________
Phone number therapist should use if Tele-Health Sessions are disrupted: _______________________________

For withdrawal from a telemedicine evaluation, please complete the information at the end of this document.

Local area crisis services: AGORA Crisis Line (505)277-3013, UNM Mental Health Line (505)272-2800, and Albuquerque Rape Crisis Center (505) 266-7711________________. (Client Initials)

(SIGN BELOW FOR WITHDRAWAL ONLY). I have chosen not to participate further in this telemedicine evaluation or sessions.
Signature of patient (and/or): ____
Date: ____________ Signature of parent/guardian: ____