INFORMED CONSENT FOR TELEHEALTH SERVICES

Participant Name: _____ DOB: _____

Telehealth services do not change your rights to privacy or your protected health information. Domestic Abuse Project Telehealth Services involve the use of HIPAA compliant, live, two-way interaction between the participant and provider using audio-visual technology for the delivery of mental health services to and from remote locations. These interactive systems are compliant with current privacy regulation.

By signing this consent form:

- I consent to receive outpatient mental health services by means of Telehealth technology
- I understand that I/my child and I will not physically be in the same room as my telehealth provider
- I understand that while the session is conducted via HIPAA compliant software, factors in my own environment (others present, privacy of the location) may impact the confidentiality of my sessions
- I understand that all documentation and storage of my protected health information will take place in the electronic health record utilized by Domestic Abuse Project
- I understand that either my Telehealth provider or I can discontinue the visit if the Telehealth services are not adequate for my situation
- I understand that I will be informed if individuals other than my Telehealth provider are present in the room at the time of service, and I have the right to request non-service-related personnel to leave the room and/or terminate the service
- I understand that my provider can terminate Telehealth services if they determine that I would receive a greater benefit from in-person services. My provider will assist me in locating the appropriate resources and will complete the referral.

This authorization expires one year from the date indicated below.

_____ _____

Signature of Participant/Parent/Legal Guardian **Date**