# Telehealth Informed Consent Form

I _____ hereby consent to engaging in telehealth with
Patient Printed Name

_____ as part of my medical consultation or therapy.
Clinician Name

California law has long recognized telehealth as a form of delivery of healthcare and behavioral health services which many medical providers clinicians are practicing in the state of CA and the U.S. I understand that in California, "Telehealth" or "telemedicine" is defined as a method to deliver healthcare services using communication technologies (usually in the form live videoconferencing through a computer with a webcam or via phone) to facilitate the diagnosis, consultation, treatment, and care management while the patient and provider are at two different sites. I understand that I have the following rights with respect to telehealth:

- I have the right to withhold or withdraw consent at any time before and/or during the appointment without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

- 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 treatment is generally confidential. However, there are both mandatory and permitted exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; thoughts of suicide with a plan, and expressed threats of violence towards an ascertainable victim. This information is detailed in the Student Health Center Consent that I have already signed.

- I understand that I have a right to access my medical information and copies of medical records in accordance with California State law.

**I understand that telehealth has limitations different from in-person services:**

- I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts by my clinician and use of a secure Telehealth program (Confer Zoom, **which is in the testing phase of HIPAA compliance**), that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

- I understand that appointment invitations for telehealth services and consent forms will be sent via your myvcccd.edu accounts. **I understand that e-mail communication is not a secure mode of communication and can be accessed by unauthorized people, compromising its privacy and confidentiality**. **Email communication should not be used for emergencies.**

- I understand that a potential risk of telehealth care is that specific medical/mental health concerns (or due to technical problems) may require a face-to-face appointment after the telehealth care

appointment, and that you will be referred to a health professional who can provide such services in your area.

- **I accept that telehealth does not provide emergency services**. During our first appointment, my clinician and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or text COURAGE to 741741 for free 24-hour support.

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

**I understand that I am responsible for:**

- For phone appointments:
  - ensuring I am in a "confidential space" - a quiet, private location where I will not be interrupted and cannot be overheard by others.

- For online appointments:
  - a confidential space,
  - providing the necessary computer (or other devices) and internet access with adequate speed for my appointments, and the information security on my personal computer.

- At the beginning of each appointment, I will help my clinician complete a check-in to ensure that it is appropriate to engage in my appointment by verifying my location, whether I am in a situation conducive to a private, uninterrupted appointment, and my readiness to proceed.

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

**I have read and understand the information provided above. I have discussed with my clinician, and all of my questions have been answered to my satisfaction. My electronic signature below indicates that I have no serious reservations or concerns about receiving telehealth services or receiving communications via email from my clinician.**

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| Printed Name of Student | Printed Name of Parent/Legal Guardian (If under 18) |
| Signature of Student (if a minor, signature of guardian) | Date |
| Signature and License # of Clinician | Date |