Telehealth Informed Consent Form

Indian Health Board of Minneapolis, Inc.

TOP OF LABEL HERE

I _____, consent to engaging in telehealth with Indian Health Board as a part of the therapy process and my treatment goals. I understand that telehealth services may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio and video communications.

By signing this consent, I am verifying that I understand the following:

1. I have the right to withhold or remove consent for telehealth services at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is confidential, just as it would be if I were in the clinic. I understand that the visit is transmitted over dedicated lines and cannot be accessed by any unauthorized individuals.
3. I give my consent to be interviewed by the consulting healthcare provider. I also understand that other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.
4. For Medical I understand that a limited examination may take place during the videoconference and that I have the right to ask my healthcare provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the consulting healthcare provider.
5. I agree that certain situations including emergencies and crises are inappropriate for telehealth services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.
6. I hereby release Indian Health Board, its personnel and any other person participating in my care from any and all liability which may arise from the taking and authorized use of such digital images or radiographs.
7. I have read this document and understand the risk and benefits of the telemedicine services and have had my questions regarding the services explained and I hereby consent to participate in a telehealth visit under the conditions described in this document.

_____ _____

Signature of client/parent/guardian Date

_____

Relationship

_____ _____

Witness Date