Telehealth Informed Consent Form

California law has long recognized telehealth as a form of delivery of health care and behavioral health services which many psychotherapists are practicing in the state of CA (Business Professional Code - BPC Article 12. Enforcement 2290.5) and the U.S. In California, "Telehealth" is defined as a method to deliver health care services using information and communication technologies to facilitate the diagnosis, consultation, treatment, and care management while the patient and provider are at two different sites. This form of service is usually live video conferencing through a personal computer with a webcam.

I ________________________ hereby consent to engaging in telehealth with the following College of the Canyons Student Health and Wellness Center provider(s) as part of my psychotherapy/medical treatment. I understand that "telemedicine or telehealth" 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 California. 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 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, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an identifiable victim and/ or self; and where I make my mental or emotional state an issue in a legal proceeding.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, 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. In addition, I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area.

4. 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 even get worse. If you have an emergency, feel suicidal, or homicidal please: • Call 911 • Call the LA Psychiatric Mobile Response Team at 1-800-854-7771 • Go to the nearest Hospital Emergency Room • Call the Suicide Hotline 1-800-273-8255 available 24 hours a day. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

5. I understand that I have a right to access my medical information and copies of medical records in accordance with California law. I have read and understand the information provided above.

Signature_________________________________ **Date**____________________

Student ID_______________

Full Name _________________________________ **Date of Birth** _____________