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Telehealth Informed Consent Form

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 client and provider are at two different sites. This form of service is usually over phone or live video-conferencing through a personal computer with a webcam.

I understand that " 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 consent to engaging in telehealth with Nassiba Cherif, LMFT as part of my therapy.

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 and mental health 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 ascertainable victim; 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 health 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 therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a therapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of therapy, and that despite my efforts and the efforts of my therapist, my condition may not improve.

If you have an emergency, feel suicidal or homicidal please:

1. Call 911
2. Go to the nearest Hospital Emergency Room
3. Call or visit Psych Emergency Services
   http://www.dhs.saccounty.net/BHS/Pages/Mental-Health-Services.aspx
4. Call the National Suicide Prevention Lifeline 1-800-273-8255

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

(5) I understand that I have a right to access my health information and copies of health records in accordance with California law.

I have read and understand the information provided above.

Client Name: _____

Client Signature_____ Date _____