

**MAP YOUR CARE:
ILLNESS & GRIEF
COUNSELING, LLC**

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TELEHEALTH INFORMED CONSENT

Client's Name:

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Please initial on each line below:

I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Colorado at the time of this service.

I understand that telehealth billing information is collected in the same manner as a regular office visit.

I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand.

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RELEASE OF INFORMATION

Client's Name:

These risks include but are not limited to:

- It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

I certify that I have read and understand this agreement.

Date

Printed Name

Signature