**Informed Consent for Telehealth DWI Services**

**Introduction:**

Telehealth refers broadly to electronic and telecommunications technologies and services used to provide care and services with a provider in one location and you in another location. *(Agency name)* is currently using *(telehealth platform name(s))* to provide *(description of services).*

As part of a telehealth session, you and your provider will communicate and exchange confidential or protected health information via a Telehealth Platform. The information that is exchanged may be used for diagnosis, counseling, follow up, and/or education, and may include the following:

* Client health information
* Live, two-way audio and video
* Sound and video files

To the extent feasible, electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and protected health information and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

**Benefits and Risks of Telehealth and Telephonic Counseling:**

Expected benefits of telehealth services include but are not limited to,

* Increased access to substance use, mental health and other behavioral health services
* Client convenience that removes traditional barriers such as transportation.

Potential risks and limitations of telehealth services include but are not limited to,

* In unusual instances, failure of privacy or security protocols causing a breach of privacy or loss of confidential personal health information
* Unexpected technology problems with software compatibility, internet connection(s), and/or failure of equipment (i.e. computer, tablet, etc.) and related delays in evaluation and treatment
* Counselors may miss important non-verbal communication that is not visible or detectable during telehealth sessions

**\_\_\_\_\_\_\_\_**  I understand that the above expected benefits and potential risks are associated with telehealth services, but no results can be guaranteed or assured.

**Electronic Communications:**

Necessary Equipment:

* A device through which to conduct telehealth, including a screen, microphone, video camera and speaker, such as, a computer (PC or Mac) tablet (Android or iOS) or smart phone (Android or iOS). Computer or tablet preferred.
* Access to email address authorized by you for use on the device that you will use for access to hyperlinks to join videoconferences (when applicable) and transmission of intake and/or orientation paperwork (ex. authorization to release confidential information)

\_\_\_\_\_\_ I understand that by providing my telephone number and/or email address in the designated areas below, and by signing this Informed Consent, I am authorizing *(agency name)* to provide me information via phone, voicemail, and/or email regarding my assessment, treatment, payment information, scheduled sessions, links to videoconferences, E508 status and other information regarding the services I am receiving. Information that I provide through email will not be forwarded to independent third parties without having prior written consent from me to do so, except as authorized and/or required by law.

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Technology Issues**

**\_\_\_\_\_\_** I understand that in the event that the session is interrupted because of technology issues, I will disconnect from the session. *(Agency may edit to include their own policy. Example policy:)* I will attempt to re-contact my counselor via the telehealth platform on which we agreed to conduct sessions. If I do not reconnect within two (2) minutes, then my counselor will call me on the phone number I have provided (above).

**Confidentiality**

The laws that protect the confidentiality of clients’ health information also apply to telehealth. Your counselor has a legal and ethical responsibility to make the best efforts to protect all communications that are a part of telehealth and telephonic counseling. However, electronic communications technologies are not 100% guaranteed. Additionally, every client utilizing telehealth and telephonic services should take reasonable steps to ensure the security of communications, including, but not limited to secure networks, password protected devices, and private space/room where other cannot see participants, overhear or interrupt sessions.

\_\_\_\_\_\_\_ I understand the risks to confidentiality and will make every effort to protect telehealth and telephonic communications for my own protection and for the protection of confidentiality of others.

**Records**

Telehealth sessions will not be recorded in any way unless agreed to in writing by mutual consent. *(Agency Name)* will maintain a record of our session in the same way that in-person sessions are maintained in accordance with State and Federal laws, as well as, agency policy. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may receive copies of this information for a reasonable fee.

**Client Consent to Use of Telehealth:**

This telehealth consent is intended as a supplement to the Service Agreement signed at the onset of clinical services and does not amend any of the terms of that Service Agreement. I have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent to participate in telehealth services under the terms described in this document.

Your counselor’s signature indicates that this document has been reviewed with you to ensure that the terms described in this document are understood and agreed upon.

I hereby authorize *(Agency Name)* to use telehealth in the course of providing services to me.

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor’s Signature

& Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_