BHFS Medical & Behavioral Services
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Telehealth Informed Consent Form

I _____(patient's name), hereby consent to engage in telehealth with BHFS Medical & Behavioral Services as part of my medical and/or mental health service. I understand that "telehealth" includes the practice of health care delivery, diagnosis/evaluation, 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 Texas.

Because of recent advances in communication technology, the field of tele-therapy has evolved. It has allowed individuals who may not have local access to medical and mental health professionals to use electronic means to receive services. Because it is relatively new, there is not a lot of research indicating that it is an effective means of receiving services. An important part of medical and mental health support is sitting face to face with an individual, where non-verbal communication (body signals) is readily available. Without this information, telehealth may be slower to progress or less effective. With the telephone, the patient's tone of voice, pauses and choice of words become especially important.

Because our professionals may not meet you in person, we may request that you be interviewed by a professional in your area.

With telehealth, there is the question of where is the service occurring – at the professional's office or the location of the patient? The law has not yet clarified this issue; therefore, it is our policy to inform patients that they are receiving services from our office and therefore are bound by the laws of the State of Texas. In addition, patients must reside within the State of Texas. These laws are primarily related to confidentiality as outlined in this form.

As a patient, 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 nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled to.

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 treatment 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 the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.

4) 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 medical or mental health professional, 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.

5) I understand that telehealth-based services and care may not be as complete as face-to face services. I also understand that if my licensed medical professional or licensed mental health professional believes I would be better served by another format of services (e.g. face-to-face services,) I will be referred to the appropriate professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my medical or mental health professional, my condition may not be improved, and in some cases may even get worse.

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

7) I understand that if I need emergency medical or mental health services, I may contact my local emergency room.

8) I understand that I have a right to access my medical information and copies of medical records in accordance with the Texas law.

I have read and understand the information provided above. I have discussed it with my medical or mental health professional, and all of my questions have been answered to my satisfaction.

Patient(s) Printed Name:_____

Signature (parent/guardian if patient is a minor):_____

Relationship to patient: _____

Date:_____