

PM FORM 3.11.1
Informed Consent to Participate in Telemedicine Services

I, _____, have been asked to receive behavioral health services via telemedicine. I have been informed of my diagnosis and proposed telemedicine treatment plan. I understand that I will be receiving health care services through interactive videoconferencing equipment. I understand that, at this time, there are no known risks involved with receiving my care in this way.

I understand that the equipment will be shown to me and I will see how it works before I receive any services. I understand that my participation in telemedicine is voluntary and I may refuse to participate or decide to stop participation at any time. I understand that my refusal to participate or decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of my revocation of informed consent to treatment.

I understand that my privacy and confidentiality will be protected. I also understand that the likelihood of a videoconference being intercepted by an outsider is similar to the potential interception of a phone call. When I am receiving services via telemedicine, I will be notified as to who is in the room at the remote site.

I understand that the health care providers at both my location and the remote video site will have access to any relevant medical information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records.

I have read this document and I hereby consent to participate in receiving behavioral health services via telemedicine under the terms described above. I understand this document will become a part of my medical record.

Please check the appropriate box below.

- I agree to participate in and receive behavioral health services via telemedicine.
- I have chosen not to participate in telemedicine sessions.

Member Signature

Date

Witness Signature

For translation or alternative format requests, call 1-800-640-2123

Para recibir esta forma en espanol, llame a 1-800-640-2123

NORTHERN ARIZONA REGIONAL BEHAVIORAL HEALTH AUTHORITY (NARBHA)

1300 South Yale Street, Flagstaff, AZ 86001

(928) 774-7128

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The above release is given on behalf of _____ because the member is a minor or has been determined to be incompetent to give medical consent.

Parent, Legal Guardian, or Government Agency
Authorized by the Court (Copy of Court Order Attached)

Date

Relationship to Client

Witness

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