STATE OF CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES



N	ame	Λf	Cli	Δn	4

Patient/Client (Last Name, First Name)	Date of Birth	MPI#	Last 4 digits of SS#
Informed Consent	for Videoconference	Telemedicine Sess	sion(s)
I,understand that I will be receiving health car understand that, at this time, there are no known	e or evaluation services thr	ough interactive video	oconferencing equipment. I
I understand that my participation in telemed participation at any time, verbally or in writi- participation will be documented in my medi	ng. I understand that my re	fusal to participate or	
I understand that my privacy and confidential videoconference being intercepted by an outreceiving services via telemedicine, I will be	sider is similar to the poten	tial interception of a p	hone call. When I am
I understand that the health care providers or any relevant medical information about me, i drug abuse, and mental health records.			
I have read this document and I hereby consequent the terms described above. I understan		•	
Please check the appropriate box below.			
[] I agree to participate in and receive beha	avioral health services via t	elemedicine.	
[] I choose Not to participate in or receive	behavioral health services	via telemedicine.	
This authorization, if not cancelled, will ex	pire on (date):		
Date is not to exceed 12 months, event or c expire 12 months from the date of signature	•	uthorization expires. Į	f blank, authorization will
Signature of Patient/Client/Authorized (Legal) Re	epresentative		Date
[] I have received verbal consent from the Patie	ent/Client above or Authorize	d (Legal) Representative	e for telemedicine session(s).
Signature of Provider and/or Evaluator			Date
A copy of this authorization will be provided to t	he Patient/Client/Authorized	Representative as reques	ted.
CANCELLATION/REVOCATION: Signature	e of Patient/Client/Authorized	l (Legal) Representative	Date

A DMHAS approved Authorization for Use and Disclosure of Protected Health Information form must accompany this Informed Consent for Videoconference Telemedicine Session(s).