**STATE OF CONNECTICUT**
**DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES**

**Name of Client:**

_____

Patient/Client (Last Name, First Name) Date of Birth MPI # Last 4 digits of SS#

# Informed Consent for Videoconference Telemedicine Session(s)

I, _____, have been asked to receive clinical, medical and/or behavioral health services via telemedicine. I understand that I will be receiving health care or evaluation 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 my participation in telemedicine is voluntary and I may refuse to participate or decide to stop participation at any time, verbally or in writing. I understand that my refusal to participate or decision to stop participation will be documented in my medical record and/or evaluation report.

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 (and/or) at the remote site.

I understand that the health care providers or evaluators at both my location and the remote video site will have access to any relevant clinical, and/or 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 clinical, medical, and/or 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 clinical, medical and/or behavioral health services via telemedicine.

[ ] I choose Not to participate in or receive clinical, medical and/or behavioral health services via telemedicine.

This authorization, if not cancelled, will expire on (date):_____
*Date is not to exceed 12 months, event or condition upon which this authorization expires. If blank, authorization will expire 12 months from the date of signature below.*

_____ _____
Signature of Patient/Client/Authorized (Legal) Representative Date

[ ] I have received verbal consent from the Patient/Client above or Authorized (Legal) Representative for telemedicine session(s).

_____ _____
Signature of Provider and/or Evaluator Date

A copy of this authorization will be provided to the Patient/Client/Authorized Representative as requested.

**CANCELLATION/REVOCATION:**_____ _____
Signature of Patient/Client/Authorized (Legal) Representative Date

Revised 5/21

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