PATIENT CONSENT FOR TELEMEDICINE AND TELEHEALTH SERVICES

Name: _____ Case #: _____Date:_____

I have been asked by my health care provider to receive telemedicine services. The purpose is to assess and/or treat my psychiatric and/or other medical condition. This is done through a two-way audio/video link with a health care provider.
I understand that:

1. I, my health care provider, or both of us will talk through the audio/video link with the health care provider
2. If a doctor or nurse is working with me, some parts of a physical exam may be completed. I can ask that the exam and/or audio/video link be stopped at any time.
3. The potential risks and benefits have been discussed with me. I understand these may include (but are not limited to):

   Potential Benefits:
   - Increased accessibility to mental health care and to specialty services
   - Convenience for me

   Potential Risks:
   - Interruption or disconnection of the audio/video link
   - A picture that is not clear enough to meet the needs of the evaluation.
   - Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment
   - The audio/video link is conducted through the internet. There is a small chance that someone could tap into this session, if security protocols fail.
   - A lack of access to all the information that might be available in an in person visit. This could lead to errors in medical decision making.
4. If any of these risks occur, or if the distant site provider determines there is a reason for me not to participate, then the telemedicine or telehealth service might need to be stopped. If the service is stopped for any reason, the staff at my location will work with me to develop a follow up plan.
5. I authorize the release of any relevant medical information that pertains to me to the health care provider at BTCS, or their agents. This information may include my name, age, birth date, or other information that is necessary to conduct this telemedicine or telehealth service.
6. I understand that this service will become part of my medical record kept by BTCS.
7. I understand that I will not receive any royalties or other compensation for taking part in this service.
8. I understand that I must give my informed consent to participate in this service.
9. I acknowledge that I have received BTCS notice of Privacy Practices, or that I have reviewed the notice on the BTCS website.
10. I know how to contact the Texas Medical Board (1-800-201-9353) if I am seeing a doctor and have a complaint, and understand that this information is also posted on the Bluebonnet Trails Community Services website.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand its contents, and I give my consent to receive telemedicine and telehealth services. This consent remains in effect unless revoked in writing.

Signature of Patient: _____Date:_____

Signature of Witness:_____Date:_____

Or:
The above release is given on behalf of (patient)_____ because the patient is a minor or has been determined unable to give medical consent.

Signature of Parent or Legal Guardian: _____Date: _____

Relationship to Patient: _____

Signature of Witness: _____Date: _____