

**INFORMATION AND**

**CONSENT FORM FOR TELEPSYCHIATRY and TELEHEALTH SERVICES**

Introduction

Telepsychiatry/Telehealth is the delivery of mental health services using interactive audio and visual electronic systems where the psychiatrist, care manager, therapist, peer support specialist, care manager assistant, and/or the individual are not in the same physical location. The interactive electronic system used in telepsychiatry, and telehealth uses security protocols to protect the confidentiality of the individual’s information and audio and visual data. These protocols safeguard the data and aid in protecting against intentional or unintentional corruption.

My Rights

* I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
* I understand that the technology used is encrypted to prevent the unauthorized access to my private medical information.
* I have the right to withhold or withdraw my consent to the use of telepsychiatry and telehealth during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
* I understand that my psychiatrist and/or clinical team have the right to withhold or withdraw consent for the use of telepsychiatry/telehealth during the course of my care at any time.
* I understand that the rules and regulations which apply to the practice of medicine at the national and state level also apply to the care I will receive through my telepsychiatrist. These regulations include, but are not limited to, the Health Insurance Portability and Accountability Act (HIPAA) **(**[**42 U.S.C. § 300gg**](http://www4.law.cornell.edu/uscode/html/uscode42/usc_sup_01_42_10_6A_20_XXV_30_A.html)**,** [**29 U.S.C § 1181**](http://www4.law.cornell.edu/uscode/29/ch18schIstBp7spA.html)et seq., and[**42 USC 1320d et seq.**](http://www4.law.cornell.edu/uscode/html/uscode42/usc_sup_01_42_10_7_20_XI_30_C.html)), and Substance Use Disorder treatment provisions (42 CFR § 2.3(a)), and the Michigan Mental Health Code (PA 258 et seq. of 1974).

My Responsibilities

* I will not record any telepsychiatry/telehealth sessions without written consent from my psychiatrist and/or other clinical team members. No recordings of my telepsychiatry/telehealth sessions will occur without my written consent.
* I will inform my psychiatrist, care manager, therapist, or other clinical team members if any other person can hear or see any part of our session before the session begins. My psychiatrist, care manager, therapist, or other clinical team members will also inform me if any other person can hear or see any part of our session before the session begins.
* I understand that I must be a resident of the State of Michigan to be eligible for telepsychiatry and telehealth services from Sanilac County Community Mental Health Authority.
* I understand that my initial evaluation will not be done by telepsychiatry and/or telehealth except in special circumstances. As with any of my care with Sanilac County Community Mental Health Authority, I will be required to verify my identity before services will be provided.

Individual Consent to the Use of Telepsychiatry and Telehealth

I have read and understand the information provided above regarding telepsychiatry/telehealth and have had my questions answered. I hereby give my informed consent for the use of telepsychiatry and/or telehealth in my medical care and authorize Sanilac County Community Mental Health Authority to use telemedicine in the course of my diagnosis and treatment.

[ ]  Telehealth [ ]  Telepsychiatry

Individual Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Individual (or person authorized to sign for Individual): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness for Verbal Consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_