Independent Management Services

Providing Human Services to Families in Southern Minnesota

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INFORMED CONSENT FOR TELEHEALTH SERVICES (Mental Health)

Telehealth Services allow my therapist/mental health practitioner/Certified Family Peer Specialist to diagnose, consult, treat and educate using interactive audio, video and/or data communication regarding my treatment. I hereby consent to participating in psychotherapy/mental health services via the internet (herein referred to as Telehealth) with the clinician(s) listed below:

Client Name: _____

Clinician/Therapist: _____

Mental Health Practitioner:_____

I understand I have the following rights under this agreement:

- I have a right to confidentiality with Telehealth, under the same laws that protect the confidentiality of my medical information for in person psychotherapy/services. Any information disclosed by me during the course of my therapy/services, therefore, is generally confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse as well as any threats of violence I may make towards a reasonably identifiable person.
- I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist/mental health practitioner/CFPS has the right to break confidentiality to prevent the threatened danger.
- Further, I understand that the dissemination of any personally identifiable images, or the information from Telehealth interaction, to any other entities shall not occur without my written consent.
- I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
- I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy/mental health service sessions or other communication by my therapist/mental health practitioner/CFPS to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.
- In addition, I understand that Telehealth treatment is different from in-person therapy/mental health services and that if my therapist/mental health practitioner/CFPS believes that I would be better served by another form of therapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist/mental health practitioner/CFPS and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to Telehealth communications by providing written notification to Independent Management Services at the address above. My signature below indicates that I have read this Agreement and agree to its terms.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____