St. Clair County Community Mental Health Authority

Informed Consent to Participate in Behavioral Health Telepsychiatry Services

Individual: _____ Case #: _____

In order to receive telepsychiatry services this consent MUST be completed prior to initial appointment. This consent will remain valid until date of discharge. If there are any questions or assistance is needed, please notify case holder.

Please review the bulleted items:

- I have been offered behavioral health services via telepsychiatry and understand I will be receiving services or consultation through HIPPA-compliant interactive videoconferencing equipment.
- I understand I will be notified as to who is in the room when services or consultation is provided to me when using the videoconferencing equipment.
- I understand my privacy and confidentiality is a priority. The equipment used will have security protocols in place to limit the possibility of the videoconference being intercepted.
- I understand the healthcare providers at my present location and the remote video site will have access to my health records which include relevant medical information about me including information regarding psychiatric, psychological, HIV, alcohol and/or drug use. I have authorized the use of this information by signing a release of information and this consent to participate in behavioral health telepsychiatry services.
- I understand I have the right to stop participating in telepsychiatry services at any time and the consequences of my decision have been explained to me.

Please Check one of the Boxes Below:

◉ I have read this document in its entirety and AGREE to participate in behavioral health services via telepsychiatry/videoconferencing.

○ I have read this document in its entirety and I have chosen not to participate in telepsychiatry services or consultation.

_____	_____	_____	_____
Individual/Patient Signature	Date	Parent/Guardian Signature	Date