Telehealth Consent Form

Columbia Community Mental Health (CCMH) recognizes that telehealth services may be used to increase access and improve the quality of healthcare services to individuals. CCMH may offer telehealth services when the agency determines there to be a significant barrier to providing face-to-face services.

Telehealth Definition: I understand that telehealth is the practice of delivering behavioral health services via technology assisted media or other electronic means between a provider and a client, or group, who are located in different locations within the state of Oregon. CCMH offers in-clinic telehealth with providers off-site to expand our ability to serve a rural community. We also offer non-office based telehealth services to address barriers to in-clinic services and client convenience if eligible.

Consent: I understand that I have the right to withdraw consent to telehealth services at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled

Potential Risks: I understand that there are risks and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies

Potential Benefits: Telehealth services has benefits, including but not limited to: less limited by geographical location and transportation concerns, decrease in travel time and ability to meet virtually during inclement weather conditions, ability to participate in treatment from my own home or other environment where you feel safe, secure, and comfortable.

Session Disruption: I understand that I may experience issues with compatibility of technology or get disconnected. As a result, my provider will obtain a callback number to reach me should there be a disconnection. In the event of a technology breakdown, causing a disruption of the session, my provider will have a backup plan in place. If the technical issue cannot be resolved, your provider may elect to complete the session over the phone and may schedule future visits in-office if the problem is on-going.

Confidentiality: I understand that CCMHs Notice of Privacy Practices and the privacy laws that protect the confidentiality of my protected health information also apply to telehealth services. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. Technologies utilized by CCMH are compliant with CCMH policy, privacy and security standards of HIPAA, and the Oregon Health Authoritys Privacy and Confidentiality Rules set forth in OAR 943, Division 14

Mandatory Reporting: I understand that my provider is a mandatory abuse reporter and is required by law to notify appropriate authorities if they have reason to believe based on observation or interaction that I am an immediate risk of harm to self or others or if my provider has reason to believe a child or dependent adult (such as an older adult or person with a disability) is, or has been, in danger of physical, sexual, or emotional neglect or abuse.

Eligibility: CCMH is only able to provide telehealth services to clients located in Oregon where our clinicians hold valid OR state licenses and where we are licensed as an agency. Non-office based telehealth services may not be the most effective form of treatment for certain individuals or presenting problems. If it is believed the client would benefit better from another form of service (e.g. face-to-face or in-office telehealth sessions), an appropriate recommendation will be made.

Client Expectations During Non-Office Based Telehealth Session:
Clients must have access to a computer, smartphone, or tablet with a camera, microphone, and speakers.
Internet connection with at least 750kb/s download and upload speeds.
Access to the latest version of their preferred web browser or 8*8 application
Lighting and seating that ensures a clear image of each party's face
Clothing and environment comparable to an in-office visit.
Client must disclose the physical address of their location at the start of the sessions; unknown locations will be cause for termination of the session
Client shall provide a phone number where they can be reached in the event of service disruption. Please note that service disruptions that occur when there are safety concerns/emergencies will result in a call to 9-1-1.
Session will be terminated if the client is driving or engaging in behavior that is not conducive to the therapeutic environment.

Client Expectations During Non-Office Based Group Telehealth Sessions:
In order to maintain the groups privacy it is required that no persons, other than yourself, are in hearing or visual proximity to you during the group meeting.
Recording of the telehealth group meeting by members is strictly prohibited. It is client's responsibility to disable computer and device-generated recording. Clients may be subject to legal action by group members if they create or share any audio or video recordings of group meetings.
Although guarantees cannot be provided by the group facilitator(s), group members must agree to maintain the confidentiality of other group members. This means that clients may not disclose names or other identifying information about group members, nor may they discuss the personal issues and experiences of other members.

Emergencies: I understand that before receiving telehealth services, my provider will obtain my physical location in case of a psychiatric or medical emergency during a session. If there is a concern about safety, emergency services may be contacted.

☐ **Signature:** I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my consent to engage in telehealth services treatment. **

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name:

Relationship to Individual:

Description of Authority to Act for the Individual:

***** ***Indicates required field***

Complete