



County of San Luis Obispo Behavioral Health  
Consent for Telehealth

Client Name \_\_\_\_\_ Client ID # \_\_\_\_\_

## Consent for Telehealth

**Effective/Start Date** \_\_\_\_\_

**I hereby agree to receive telehealth services from County of San Luis Obispo Health Agency and its contracted mental health and substance use disorder providers and agree that this is an acceptable mode of delivering health care related services to me in accordance with the terms of this consent form. I understand and agree to the following statements regarding telehealth:**

- Telehealth services include the use of video teleconferencing solutions to provide services to a client via electronic interactive audio and video telecommunication from a distant location. Telehealth services are considered face-to-face because the client is visually present. I understand that my provider will not be physically in my presence.
- Telehealth services will be provided to me for purposes of evaluation, diagnosis, management, and treatment.
- The treating provider performing the examination or treatment will keep a record of the consultation in my electronic healthcare record.
- All the information discussed via telehealth is held to the same privacy standards as that of an in-person appointment.
- Should I feel for whatever reason telehealth is not a comfortable means of conducting my treatment sessions, I have the right to withdraw consent for telehealth services at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- There are risks, benefits, 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.



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- When using my own personal electronic device, County of San Luis Obispo Health Agency does not have any control or authority over the protection of my health information that may be stored within my device. I understand that information stored within my device may be at risk, for example, if lost or stolen.
- 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. Audio/visual recording may be allowed with a separate written consent. Such recordings are for staff training purposes only, are not part of the medical record, and are destroyed after intended use.
- Although my provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency, I understand that my provider will be unable to render in-person emergency assistance if I experience a crisis during a telehealth session.
- I have a right to access covered services in person. I understand that non-medical transportation benefits are available for in-person visits.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent / Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship \_\_\_\_\_

Staff Signature \_\_\_\_\_

Date \_\_\_\_\_