CONSENT FOR TELEPSYCHIATRIC SERVICES

What are Telepsychiatric services and when are they used?
Telepsychiatric services are used when mental health staff cannot be physically present with you to evaluate your mental health needs and, if appropriate, prescribe medications. Mental health staff may be present at another location and available to serve you through newly available technology. Instead of talking to someone on the phone at another location, Telepsychiatric services use a video camera and computer to send both voice and personal images (pictures) between you and mental health staff so not only can you talk to each other, but you can also see each other. This allows mental health staff to make a better evaluation of your needs.

How do Telepsychiatric services work?
You will be in a private room either by yourself, with a friend, family member, or staff person. The room will have a computer with a video camera. The mental health staff will also be in a private room but at another location with the same type of equipment. When the session is ready to begin, clinic staff will start the computer and camera so that you and mental health staff can see each other and talk together. When the session is over, clinic staff will shut off the equipment.

How is it different than a regular session with mental health staff?
Other than you and mental health staff not being in a room together, there is very little difference in the session. Mental health staff will ask and document clinical information that you share with him/her, send any prescriptions that are ordered to the pharmacy for you to pick up if medications are prescribed, document the service that is provided, and ensure that documentation is included in your clinical record for future reference.

What happens if I choose not to consent to Telepsychiatric services?
If you choose not to consent to Telepsychiatric services, we will be unable to provide you with convenient and readily available services and your services will be rescheduled for a later date and/or a different site.

I understand that:

1. I have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The potential benefit of Telepsychiatric services is that I will be able to talk with mental health staff today from this local setting for an evaluation of my needs. When appropriate, I will be able to participate in mental health services, start on medication today, or continue my current medications uninterrupted.
3. The potential risk of Telepsychiatric services is that there could be a partial or complete failure of the equipment being used which could result in mental health staff's inability to complete the evaluation, mental health services, and/or prescription process.
4. There is no permanent video or voice recording kept of the Telepsychiatric service's session.
5. All existing confidentiality protections apply.
6. All existing laws regarding client access to mental health information and copies of mental health records apply.
7. Dissemination of client identifiable images or information from the Telepsychiatric interaction to researchers or other entities shall not occur without the consent of the client.

I, _____, consent to Telepsychiatric services in circumstances in which mental health staff appropriate to my needs is not immediately available at my site. My mental health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I understand the written information provided above.

_____	_____	_____
Signature of Client	Signature of Witness	Date
_____	_____	_____
Legal Representative*	Relationship to Client	Date

☐ Client is willing to accept Telepsychiatric services, but unwilling to sign the Consent for Telepsychiatric Services.

☐ I have completed or have caused to be completed the Consent of Minor form for any client under the age of 18 signing without legal representative* consent and I affirm the client meets all eligibility criteria as noted on the Consent of Minor form to receive medication without legal representative consent.

_____ Signature of Client _____ Date

This consent was translated into _____ for the client and/or responsible adult/legal representative.

A copy of this Consent ☐ was given ☐ declined on _____ (Date) by _____ (Initial)

* Legal Representative = Parent, Authorized Caregiver, Guardian, Conservator, or Personal Representative for treatment

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.	Name: _____ IBHIS/IS #: _____ Agency: _____ Provider #: _____ **Los Angeles County Department of Mental Health**