Telemedicine Informed Consent Form

I _____ (guardian) hereby consent to _____(patient) engaging in telemedicine services with Region 9 School Based Health Services, as part of my psychotherapy and medication management. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to health care Practitioners located at Region 9 SBHC in Ruidoso, NM.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss of any program benefits to which I would otherwise be entitled.
(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed to me during the course of therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse, expressed threats of violence towards ascertainable victims; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.
(3) I understand there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of Region 9 SBHC, that: the transmission of my medical information could be disrupted or distorted by medical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telemedicine based services and care may not be as complete as face-to- face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (eg. Face to face services) I will be referred to a psychotherapist who can provide services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and efforts from my psychotherapist, my condition may not improve, and in some cases get worse.
(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
(5) I understand that I have the right to access my medical information and copies of medical records in accordance with New Mexico law.

I have read and understand that information provided above and can discuss and further questions with my psychotherapist or other staff at Region 9 School Based Health Services.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date