COLUMBIA COMMUNITY MENTAL HEALTH
TELEHEALTH SERVICES INFORMED 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.

I understand the following in respect to telehealth services:

1. **Telehealth Definition:** I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a provider and a client, or group, who are located in different locations.
2. **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.
3. **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.
4. **Potential Benefits:** Telehealth services have potential benefits including easier access to care, continuity of care, increased social connection, and the convenience of meeting from a location of your choosing.
5. **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.
6. **Confidentiality:** I understand that CCMH's 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 Authority's Privacy and Confidentiality Rules set forth in OAR 943, Division 14.
7. **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 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.
8. **Limitations:** I understand that there may be times when a service may not be available via telehealth. My provider will discuss any service specific limitations with me.
9. **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. Should an emergency occur, my provider will assist me in contacting emergency services if I am unable to the best of their ability.

I agree to the following requirements for participation in group telehealth services:

10. In order to maintain the group's privacy it is required that no persons, other than yourself, are in hearing or visual proximity to you during the group meeting.
11. Recording of the telehealth group meeting by members is strictly prohibited. It is your responsibility to disable computer and device-generated recording. You may be subject to legal action by group members if you create or share any audio or video recordings of group meetings.

12. 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 you may not disclose names or other identifying information about group members, nor may you discuss the personal issues and experiences of other members.

By signing below, I certify:

I have had this form explained to me with the opportunity to ask questions about telehealth service delivery and have received satisfactory answers to my questions. I provide my consent to receive telehealth services from CCMH.

_____	_____
Client Printed Name	Client Date of Birth
_____	_____
Client/Client Representative Signature	Date