INFORMED CONSENT FOR TELEPSYCHIATRY/THERAPY SERVICES

PURPOSE: The purpose of this form is to obtain your consent to use technology/telemedicine as a medium while participating in receiving services from Rimrock.

MEDICAL INFORMATION AND RECORDS: All existing laws regarding privacy and security of your health information and copies of your medical records apply to this telemedicine health service. Any dissemination of patient-identifiable information from these interactions for purposes other than your treatment, payment for healthcare services you receive, and certain necessary administrative and operational activities supporting your care shall not occur without your authorization.
As such, the information disclosed 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 and expressed threats of violence towards an ascertainable victim.

METHODS: Telepsychiatry may occur through secure computer camera/audio programs initiated by Rimrock. Note that computers or computer servers outside of Rimrock's control may not have the necessary security to protect HIPAA, 42CFR Part 2, and other privacy information.

Other methods of communication could include cell phone use or texting. Rimrock takes all necessary Precautions in securing electronic information; however, despite reasonable efforts, transmission of care via telemedicine could be disrupted or distorted by technical failures, the medical information could be interrupted by unauthorized persons.

Please note that Rimrock may not respond to emails or texts immediately and that, for this reason, these modes of communication should not be used in case of emerge. IF you are concerned for the health or safety of yourself or other, please call 911.

RIGHTS: You may withhold or withdraw your consent to the telemedicine health service at any time before or during the consult without affecting the right to future care. The request to revoke consent must be in writing and received by Rimrock.

I have read and understand the information provided above regarding telemedicine, have discussed it with my provider/clinician, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine for my care.

_____ _____
NAME DATE

_____ _____
PROVIDER/CLINICIAN DATE

SUBMIT