

**PM FORM 3.11.2**

**Informed Consent to Participate in Telemedicine Services**

I, \_\_\_\_\_, have been asked to receive behavioral health services via telemedicine. I have been informed of my diagnosis and proposed telemedicine treatment plan. I understand that I will be receiving health care services through interactive videoconferencing equipment. I understand that, at this time, there are no known risks involved with receiving my care in this way.

I understand that the equipment will be shown to me and I will see how it works before I receive any services. I understand that my participation in telemedicine is voluntary and I may refuse to participate or decide to stop participation at any time. I understand that my refusal to participate or decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of my revocation of informed consent to treatment.

I understand that my privacy and confidentiality will be protected. I also understand that the likelihood of a videoconference being intercepted by an outsider is similar to the potential interception of a phone call. When I am receiving services via telemedicine, I will be notified as to who is in the room at the remote site.

I understand that the health care providers at both my location and the remote video site will have access to any relevant medical information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records.

I have read this document and I hereby consent to participate in receiving behavioral health services via telemedicine under the terms described above. I understand this document will become a part of my medical record.

**Please check the appropriate box below.**

I agree to participate in and receive behavioral health services via telemedicine.

I have chosen not to participate in telemedicine sessions.

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

**For translation or alternative format requests, call 1-800-640-2123  
Para recibir esta forma en español, llame a 1-800-640-2123  
NORTHERN ARIZONA REGIONAL BEHAVIORAL HEALTH AUTHORITY (NARBHA)  
1300 South Yale Street, Flagstaff, AZ 86001  
(928) 774-7128**

**Last Revised Date: 10/15/2009**

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The above release is given on behalf of \_\_\_\_\_ because the member is a minor or has been determined to be incompetent to give medical consent.

\_\_\_\_\_  
Parent, Legal Guardian, or Government Agency  
Authorized by the Court (Copy of Court Order Attached)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Witness

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