aspire health alliance

Telehealth Informed Consent

Today's Date: _____

Medical Record #: _____

Client: _____ **Date of Birth: _____**

- **Consent to Telehealth Treatment:** I hereby consent to receive psychological/behavioral health assessment and/or treatment by Aspire Health Alliance via telehealth. I understand that telehealth includes the practice of care delivery, diagnosis, consultation, treatment, transfer of health information, therapeutic interventions, education, and other services using interactive audio, video, telephone, or data communications.
- **Confidentiality:** I understand that information about me will be kept confidential. I understand that records and information about me shall not be released without my consent or the consent of my authorized representative, except where the release is in accordance with applicable law. I understand the legal limitations on the confidentiality of my communications, including, without limitation, that disclosure may occur in certain circumstances in legal proceedings or to protect myself or others. The Aspire Health Alliance Notice of Privacy Practices further states Aspire Health Alliance obligations to protect your privacy.
- **Withdrawal from Telehealth Treatment:** I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- **Recommended Treatment Modality:** I understand that telehealth is not the recommended treatment modality for many clients including, but not limited to: clients who are actively suicidal or homicidal, clients with active substance abuse issues, clients with severe psychiatric conditions, clients in violent situations, etc. I understand that if telehealth services are not clinically indicated as appropriate, that I may be offered a treatment modality that will be better suited to my needs.
- **Right to Access:** I understand that I have the right to access my health information and copies of records in accordance with state laws.
- I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

I acknowledge that I have read/had read and/or had explained to me all of the above and understand the guidelines to receive and continue telehealth services.

_____ _____

Date **Signature of Client/Legal Guardian**

_____

If Signing for Client, please state relationship