ATLANTA AREA PSYCHOLOGICAL ASSOCIATES, P.C.

Telehealth Services Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with outpatient mental health counseling/therapy services during the COVID19 State of Emergency.

2. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

3. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth consultation.

4. **RIGHTS:** You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

5**. DISPUTES**: You agree that any dispute arriving from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

6. **RISKS, CONSEQUENCES & BENEFITS:** You understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. You understand that your health care provider or you can discontinue the telehealth consult/visit if it is felt that the telehealth connections are not adequate for the situation. You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature: _____ Date: _____

If signed by someone other than the patient, indicate relationship: _____

Witness Signature: _____ Date: _____