



San Diego Mesa College

**San Diego Mesa College Student Health Services
Telehealth Informed Consent Form**

I(*Name here*) _____
hereby consent to engaging in telehealth with (*Practitioner name*) _____ as
part of my psychotherapy. I understand that “telemedicine” includes the practice of health care
delivery, diagnosis, consultation, treatment, transfer of medical data, and education using
interactive audio, video, or data communications.

I understand that telehealth also involves the communication of my medical/mental information,
both orally and visually, to health care practitioner who is a staff member located in California. I
understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to
future care or treatment nor risking the loss or withdrawal of any program benefits to which I
would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telehealth.
As such, I understand that the information disclosed by me during the course of my 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;
- Expressed threats of violence towards an ascertainable victim; and
- Where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information
from the telehealth interaction to researchers or other entities shall not occur without my written
consent.

(3) I understand that there are risks and consequences from telehealth, including, but not limited
to, the possibility, despite reasonable efforts on the part of my psychotherapist, that:

- The transmission of my medical information could be disrupted or distorted by technical
failures;
- The transmission of my medical information could be interrupted by unauthorized
persons;
- It is possible in today’s times that the electronic storage of my medical information could
be accessed by unauthorized persons.
- In addition, I understand that telehealth based services and care may not be as complete
as face-to-face services.

(4) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law. I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

(6) At the start of every session

- I am willing to verify my address I am at for the session in the case of an emergency that may happen during the session.
- I am willing to make a plan in case there is an electronic failure
- I will also verify that I am in the state of California at the time of the session.
- I will verify that tele-health is an acceptable form of delivering psychotherapy services to me at the time of the session
- I will make sure I am in a private space that is as free as possible from distraction
- If I am in need, I will identify a support person who I can physically or electronically make contact for personal care.

(7) I understand that in the case of a technical or internet failure, I can continue the session by telephone. If my therapist is still not reachable, I can call the Access & Crisis line at **888-724-7240** or in emergency, 911.

Client Signature: _____ Date: _____