MISSOURI DEPARTMENT OF MENTAL HEALTH
TELEHEALTH INFORMED CONSENT

I, _____, agree to participate as a consumer of _____'s
(Name of Consumer) (Provider Name)
telehealth delivery system. I will be receiving mental health services through interactive videoconferencing. I understand the use of videoconferencing is an alternative method of mental health care delivery and that my therapist will not be physically in the same room with me.

I understand that although _____ makes every effort to protect my privacy by using
(Provider Name)
a secure server, they cannot guarantee the security of any information I transmit to them over the internet. By using telehealth services, I recognize that transmissions over the internet are at my own risk and that third parties may unlawfully intercept or access the transmissions. I also understand that despite reasonable efforts on the part of my therapist, there are risks and consequences in using telehealth services. The risks include, but are not limited to, the possibility that the transmission of sessions could be disrupted or distorted by technical failures. In case of technical failures, my therapist will make every effort to re-connect with me through my case worker.

I also understand that telehealth services may not be as complete as services provided via face-to-face, although, several benefits of telehealth services have been identified including increased access to specialized services in remote areas, lower healthcare costs, reduced travel, minimizing time off work, and decreased waiting time for services. I have also been notified that if my therapist believes I would be better served by another form of counseling services (e.g., face-to-face services), I will be referred to a therapist who can provide such services. Finally, I understand that there are potential risks and benefits associated with any form of mental health service and that, despite my efforts and the efforts of my therapist, my condition may not improve and in some cases may even get worse. I understand that my participation in this is voluntary and I may decide to terminate my treatment at any time. My privacy and confidentiality will be protected.

I understand that there will be no recordings of my therapy sessions. I also agree to not record my own therapy sessions without my therapist's knowledge or permission.

I understand that the telehealth services will be provided to me free of charge.

I give my consent to receive mental health services through the telehealth system. I also understand that the services I receive will become part of record at _____ and will also be kept on file
(Referring Agency)
at _____.
(Provider Name)

Signature of Consumer:	_____	**Date:**	_____
Signature of Witness:	_____	**Date:**	_____
Signature of Parent/ Legal Guardian/Representative:	_____	**Date:**	_____