Cumberland River Behavioral Health – Telehealth
Client Information and Consent for Telehealth

Client's Name: _____ SSN:_____

Introduction:
Telehealth is the delivery of services using interactive audio and visual electronic systems where the practitioner and the client are not in the same physical location. The interactive electronic systems used in telehealth incorporate network and software security protocols to protect the confidentiality of client information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Benefits:
- Increased accessibility to care
- Client convenience

Potential Risks:
- As with any procedure, there may be potential risks associated with the use of telehealth. These risks include, but are not limited to:
- Information transmitted may not be sufficient (e.g. poor resolution of video) to allow for appropriate decision making by our practitioners.
- Our practitioners may not be able to provide treatment to me using interactive electronic equipment nor provide or arrange for emergency care that I require.
- Delays in evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential information.
- A lack of access to all the information that might be available in a face-to-face visit, but not in a telehealth session may result in errors in medical judgement.

Alternatives to the Use of Telehealth:
- Traditional face-to-face sessions in an office based setting.

My Rights and Responsibilities:
- I understand that the laws that protect the privacy and confidentiality of my information also apply to telehealth.
- I understand that I have the option of face-to-face sessions instead of using telehealth and that telehealth is only being offered as an option to assist with accessibility and convenience.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth during the course of my care at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of a Medicaid benefit to which the recipient is entitled.
- I understand that CRBH has the right to withhold or withdraw its consent for the use of telehealth during the course of my care at any time.
- I understand that all rules and regulations which apply to the practice of medicine in Kentucky also apply to telehealth.
- I understand that I have access to medical information resulting from telehealth as provided by law.
- I understand that the videoconferencing technology used by my practitioner is encrypted to prevent unauthorized access to my private information.
- I understand that I must be a resident of a U.S. state in which my practitioner is licensed to practice in order to be eligible for telehealth services from CRBH and that it is my responsibility to inform my practitioner of my residency status if it changes at any time in the future.
- I understand that CRBH will not record any of our telehealth sessions without my written consent and I agree to not record any telehealth sessions without written consent from CRBH.
- I understand that my practitioner will inform me if any other person can hear or see any part of our session before the session begins and that I will inform my practitioner if any other person can hear or see any part of our session before the session begins. I understand that I and CRBH have the right to exclude anyone from either site.
- I understand the dissemination, storage, or retention of an identifiable image or other information from the telehealth shall comply with 42 U.S.C. 1301 et seq., 45 C.F.R. Parts 160, 162, 164, KRS 205.566, 216.2927, and other federal law or regulation or state law establishing individual health care data confidentiality policies.

Client Consent to the Use of Telehealth:
I have read and understand the information provided above regarding telehealth, have discussed it with my practitioner, and all of my questions have been answered from CRBH, and that it is my responsibility to inform my practitioner of my residency status if it changes at any time in the future.

Signature: _____ Date: _____
(Client or Client's Representative)
Printed Name of Client's Representative: _____ Date: _____
(Given Authority to Act for the Client)
Witness Signature: _____ Date: _____