



The Steven A. Cohen
Military Family Clinic
at the University of Pennsylvania

Consent to Telehealth Services

This is a consent to participate in telehealth services with the Steven A. Cohen Military Family Clinic at the University of Pennsylvania through a HIPAA compliant two-way audio/video link. The purpose of these services is to evaluate and treat my behavioral health condition. This care is governed by all the same protections and limitations as in person care (see Acknowledgement of Notice of Privacy Practices and Client Rights and Responsibilities).

I understand the following:

1. The potential benefits of telehealth are increased access to care and convenience.
2. The possible risks are interruption/disconnection to the audio/video link, delay in treatment due to failure of equipment, need for internet connection that may fail, and the lack of access to all information that might be available in an in-person visit.
3. I may request that telehealth-based services be discontinued at any time. If I refuse the delivery of healthcare services via telemedicine at any time, this will not affect my right to care or treatment.
4. The provider I see will determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter. If telehealth services are deemed inappropriate by my provider at any time, I will be offered a different follow-up plan.
5. The Telemedicine platform uses a high level of security and is HIPAA complaint. The security measures taken include encrypting all data, password protected access to data, and other files. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. I need to work with my provider to address any privacy issues or concerns where I am physically located during the evaluation, such as others in the room.
6. If I have an emergency outside of the session, I understand that I should call my provider.
7. If the connection is lost during a telehealth session, my provider will call me.
8. If I have any questions before, during, or after the visit, I may contact the main office.

If you refuse to sign this consent form, you are declining telehealth-based services only.

Signature or Patient or Legally Authorized Representative

Date

Printed Name of Patient or Legally Authorized Representative

Relationship to Patient