Minnesota
Mental Health Clinics

Consent for Telehealth Services

Mental health care services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as “telemedicine” or “telehealth,” this means that I will be evaluated and treated by a mental health care provider or specialist from a different location. Since this is different than the type of service from which I am familiar**, I understand and agree to the following:**

1. The mental health care provider will be at a different location from me. I will be connecting to remote services from a location in the state of Minnesota that is private and comfortable to me.
2. I will identify and sign a release of information form for an Emergency Contact (EC) who will be available to me in relative close physical proximity during all telehealth sessions in case of an emergency. I will provide the contact information for this person to my mental health provider, as well as the information for local emergency services.
3. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the consultant and presenting practitioner. I will give my verbal permission prior to additional personnel being present. I will inform my mental health care provider if someone is attending the session with me or if there are other people in the room where I am receiving telehealth services.
4. Video recordings may be taken of the telehealth session, after I have given my written permission prior to recording. Video recordings may be kept, viewed, and used for purposes including teaching, training, technical, scientific, research, or administrative purposes.
5. If I am having technological issues connecting to my telehealth session, I can call my provider directly. They will be able to assist me in connecting to services or transfer me to someone who can help.
6. I have the option to test out the telehealth technology prior to my first telehealth session with my provider. I will be provided with the appropriate connection instructions. My provider will be able to assist me with setting up a separate appointment to learn how to use the technology.

Noting all the above, I understand that my participation in the process described (called “telemedicine” or “telehealth”) is voluntary and constitutes a waiver of the usual right to provider-client privacy and may possibly increase the risk of disclosure of my personal data.

I further understand that I have the right to:

1. Refuse the telehealth session or stop participation in the telehealth session at any time.
2. Request that the presenting practitioner refrain from transmitting my information if I make the request before the information is transmitted.

I acknowledge that the mental health care providers involved have explained the sessions in a satisfactory manner and that all questions that I have asked about the sessions have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

I hereby agree to the above and that a photographic copy of this authorization is as valid as the original. This authorization expires after one year but may be revoked or limited in writing by me at anytime, but such revocation will not apply to information already released.

Client Name (please print) _____

Signature_____ Date: _____

Parent or Guardian Signature_____ Date: _____

Minnesota Mental Health Clinics Eagan Clinic-3450 O’Leary Lane, Eagan MN 55123 Phone: 651-454-0114 Fax: 651-454-3492
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Lakeville Clinic-18586 Joplin Ave., Lakeville, MN 55044 Phone: 952-435-8700 Fax: 952-435-0559
Maplewood Clinic-2785 White Bear Ave #403, Maplewood MN 55109 Phone: 651-365-8289 Fax: 651-365-8283
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Woodbury Clinic-1000 Radio Dr. Suite 210, Woodbury, MN 55125 Phone: 651-365-8209 Fax: 651-739-0272