



CONSENT TO PARTICIPATE IN TELEMEDICINE/TELEHEALTH SERVICES AND ENCOUNTERS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FIELD SERVICES

SFN 1155 (4-2025)

Client Name	Client ID	Date of Birth
Episode	Admission Date	Current Date

I consent to participate in Telemedicine/Telehealth Services. I hereby request to take part in Telemedicine/Telehealth Encounters.

☐ Yes ☐ No

To meet the needs of people in our communities, health care services are available by interactive video communications commonly referred to as "telemedicine" or "telehealth". These services may include, but are not limited to, evaluation, diagnosis, care coordination, treatment, and monitoring.

I understand that I may be evaluated and treated by a healthcare provider or specialist who is at a different and possibly distant location. I understand that other people may assist that provider or specialist with this encounter. It has been explained to me, and I understand that:

- The consulting healthcare provider or specialist may be at a different location from me. A case manager or other healthcare provider ("present") may be at the same location as I am to assist in the consultation. There may also be a technical person to operate the equipment.
- The presenter or another individual who will operate the equipment may transmit or share electronically details of my medical and clinical history, evaluations, or other clinical documents with the provider or specialist who is at a different location.
- I will be informed if any additional personnel are to be present other than: myself, individuals accompanying me, the provider or specialist, the presenter, and the technical person. I will be required to give my permission prior to the entry of additional personnel.
- The healthcare provider or specialist in a different location may request that I visit that provider or specialist in person to further evaluate my condition.

I understand that I have the right to:

- Refuse or stop participation in the telemedicine encounter at any time.
- Limit any physical examination proposed during the telemedicine consultation but recognize that a follow-up referral to a local medical or clinical provider may be recommended.
- Request that the presenter not transmit my medical information, if I make the request in writing before that information is transmitted.
- Request that non-medical personnel leave the room at any time.
- Request that all personnel leave the room to allow me a private consultation with the provider or specialist at the different location.

I agree that any questions I have about the telemedicine encounter have been answered in a satisfactory manner and consent to participate in telemedicine encounter as described above. While every effort will be made to maintain a good quality audio and video connection, there is some possibility that technology could fail.

Signature of Client or Legal Representative	Date
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