Telemedicine Informed Consent Form

Mitchell Rosen, L.M.F.T.

This form cannot be accessed directly.

Mitchell Rosen, L.M.F.T.

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I hereby give my consent to engaging in telemedicine with Mitchell Rosen, LMFT as part of my psychotherapy/evaluation. I understand that telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/psychological information, both orally and written to healthcare practitioners and other professionals located in California or outside of California.

I understand that I have the following rights with respect to telemedicine:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future services nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. The laws that protect the confidentiality of my services also apply to telemedicine. As such, i understand that the information disclosed by me is generally confidential however there are both mandatory and permissive exceptions including but not limited to reporting child, elder and dependent adult abuse; expressed threats of violence towards an ascertaining victims; and where i make my mental and emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifying images or information from the telemedicine interaction shall not occur without my written consent.

3. I understand there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of Mitchell Rosen, L.M.F.T. , that: the transmission of my medical/legal information could be disrupted or distorted by technical failures; the transmission of my medical/legal information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services and care may not be as complete as face to face services and if Mitchell Rosen, L.M.F.T. believes I would be better served by another provider of services, I will be referred to another provider in my area.

4. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

I have read and understand the information provided above and my signature affirms I agree to the utilization of telemedicine.

Signature *

Click to sign

Date field

Submit

Your message will be encrypted.

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