CONSENT TO RECEIVE MEDICAL AND BEHAVIORAL HEALTH SERVICES

VIA TELEHEALTH

(For Individuals Under the Age of 18 Only)

I hereby consent (for myself/for my child or ward) to receive Telehealth services and treatment by a Whitman-Walker Health medical or behavioral health provider, and I acknowledge the following:

- I am participating in a medical or behavioral health Telehealth visit at a location different from where my provider is located, which may limit the ability of the Whitman-Walker Health (WWH) provider to provide medical care beyond the scope of permissible Telehealth services. For example, WWH may gather information from me about my symptoms, or prescribe medication to me based on a telehealth visit, but WWH cannot provide emergency medical or behavioral health care via a Telehealth visit.

- It is the role of the WWH provider to determine whether or not the condition I am being diagnosed with or treated for is appropriate for a Telehealth visit;

- If I am experiencing a medical or mental health emergency, I understand that I will be asked to immediately call 911 or go to the nearest emergency room;

- This session and future Telehealth sessions are conducted with the use of real-time interactive two-way audio, video or other electronic communications. WWH has taken steps to protect the security of information disclosed during the session, including using HIPAA compliant electronic communications, but in rare instances security protocols could fail, potentially causing a breach of my protected health information. I agree to hold WWH harmless for any loss of protected health information that occurs due to technological failure;

- WWH will need to obtain an accurate medical and mental health history, condition(s) and description of current or previous medical or mental health care from me during Telehealth sessions to best support diagnosis, therapy, follow-up and/or education;

- WWH may share my identifiable information from Telehealth visits with third parties, except as prohibited by law. WWH may separately request your consent to share identifiable information from your Telehealth visits to third parties, as necessary;

- There are potential risks to Telehealth, including but not limited to, technological

interruptions, unauthorized access, and technical difficulties.

- My WWH provider or I may discontinue any Telehealth visit if we feel that the videoconferencing connections are not adequate for the situation;

- If I change my mind about participating in this or future Telehealth sessions, I have the right to withdraw my consent.

By signing your name below, you acknowledge that you have read, and fully understand, each of the separate paragraphs set forth above, or have had them read to you. You have had a chance to ask WWH staff any questions you may have. This consent lasts for as long Telehealth services continue, unless you exercise your right to withdraw your consent at any time.

If you are not able to place a wet signature or electronic signature on this Consent and return it to WWH, you will verbally inform WWH that you have reviewed this Form and provide verbal consent. WWH will document your consent to Telehealth services in your electronic medical record.

I UNDERSTAND THAT MY SIGNATURE BELOW ACKNOWLEDGES THAT I CONSENT TO THE TELEHEALTH SERVICES AND TREATMENT PROVIDED TO ME (OR, IF I AM SIGNING AS A PARENT/LEGAL GUARDIAN, TO MY MINOR CHILD OR WARD) BY WHITMAN-WALKER HEALTH.

_____ COURT ORDER PROVIDED WHEN APPLICABLE (copy attached)
Initials of medical provider to verify that a copy is attached

Printed Name of Patient:	**Date of Birth:**
Signature: *(If applicable)*	**Date:**
Printed Name of Parent/Legal Guardian:	
Relationship to Patient:	
Signature:	**Date:**