TCHATT PATIENT CONSENT FOR TELEMEDICINE VISIT

Patient Name: _____Patient Date of Birth:_____

School Name: _____

Parent/Legal Guardian Name (if Patient is a minor):

I am the Patient or Legally Authorized Representative (e.g. mother/father/guardian) of the Patient. At the recommendation of the Patient's school, I consent for the Patient to be seen by a Behavioral Health Provider under the direction of _____(HRI)_____ through a two-way interactive audio/video connection known as telemedicine. I understand that the purpose of this telemedicine visit is specific to a behavioral health/psychiatry assessment, short-term treatment, case management and or/ consulting services and is not a substitute for medical treatment.

In addition, I understand the following:

1. I may request that the telemedicine visit be discontinued at any time.
2. Details of the Patient medical history, including patient identifiable information, may be used or shared within ___HRI___. I authorize the release of any relevant medical information that pertains to the Patient to __HRI__ or their agents.
3. I understand that the written record of the Patient's telemedicine visit will become part of his/her medical record and will remain strictly confidential.
4. It may be necessary for the ___HRI___ healthcare provider to recommend one of the following alternative settings for healthcare treatment:
    a. Emergency care at an emergency room
    b. Follow-up outpatient visit (in-person) with another specialty provider
    c. Admission to an inpatient hospital
5. Every effort will be made to structure the telemedicine visits so there will be effective follow-up care or referral, and I will have an opportunity to express my concerns.
6. There are potential problems with the use of the technology for telemedicine. These may include but are not limited to the following:
    a. Interruption or disconnection to the audio/video link
    b. An unclear picture or image
    c. Electronic interference
    If any of these problems occur, the visit might need to be discontinued
7. ___HRI__ has taken several security measures to ensure that the transmission of the telemedicine visit is confidential and not accessed by unauthorized users. This includes the use of a Private network for connectivity or ISDN point-to-point dial-up.
8. ___HRI__ cannot guarantee the privacy or security of any telemedicine visit.
9. I understand that this telemedicine visit may not be equal to a face-to-face visit with a healthcare provider.
10. I will not receive any compensation for taking place in this telemedicine visit.

11. I understand that as part of the Texas Child Health Access Through Telemedicine (TCHATT) Program, the telemedicine visits are at no cost to me and my child. However, subsequent referrals and ongoing treatment outside of the TCHATT Program may incur costs to me or my health insurance.

I certify that this form has been fully explained to me. I have read it or have had it read to me, and I understand its contents. I understand that I can revoke this consent at any time by providing written notice to ___HRI___, and I consent to participate and have the Patient receive care via telemedicine.

Signature of Patient or Guardian: _____ Date:_____ Time: _____
Printed Name of Patient/Guardian: _____
Relationship to Patient: _____
Signature of Witness: _____ Date: _____ Time: _____
Printed Name of Witness: _____