Carol Cochrane Bass, M.A., L.M.F.T.

530 Alameda del Prado, Suite C, #193, Novato, CA 94949
MFC# 43343
carolcochranebasslmft.com
Email carolcochranebass@gmail.com
Phone: 831.425.2277

TELEMEDICINE INFORMED CONSENT FORM

I _____ [name of patient] hereby consent to engage in telemedicine with Carol Cochrane Bass, LMFT as part of my psychotherapy. 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/mental information, both orally and visually, to health care practitioners located in or outside of California.

I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer, and my privacy may thus be compromised.

I understand that I have the following rights concerning telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical

information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

Also, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases may even get worse.

(4) In the event of disruption of services, it may be necessary to communicate by telephone.

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

(6) Because I may not have met you in person, I may request that you be interviewed by a professional in your area and allow me to talk to that individual before proceeding with therapy.

(7) I understand that I have a right to access my medical information and copies of medical records by California law.

I have read and understood the information provided above. I have discussed it with my psychotherapist, and all my questions have been answered to my satisfaction.

_____ _____

Signature of patient/parent/guardian/conservator If signed by other than patient, indicate the relationship

_____

Date