Northern Human Services
Consent to Participate in Mental Health
Consultation via Videoconference

Client Name: _____ Medical Record #: _____

1. I understand that Northern Human Services has arranged for me/my child to obtain an emergency psychiatric consultation through the use of videoconferencing. I understand that the mental health care provider for this consultation is employed by Northern Human Services.
2. I understand that I will be receiving mental health services through interactive videoconferencing equipment and that, at this time, there are no known risks involved with receiving my care this way.
3. Someone has explained to me how the videoconferencing technology will be used. I understand that this consultation will not be the same as a face-to-face mental health consultation due to the fact that I will not be in the same room as the provider.
4. I understand that my participation in videoconferencing is voluntary and I may refuse to participate or decide to stop participation at any time. I understand that the consulting provider or I can discontinue the consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that my privacy and confidentiality will be protected. When I am receiving services via videoconference, I will be notified as to who is in the room at the remote site.
6. I understand that the mental health care providers at both my location and the remote video site will have access to any relevant medical information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records. I also understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
7. I have read this document carefully and I consent to participate in a mental health consultation via videoconferencing under the terms described above. I understand this document will become a part of my medical record.

Please check the appropriate box below:

_____ I agree to participate in a videoconferencing mental health consultation.

_____ I do not agree to participate in a videoconferencing mental health consultation.

_____   _____
Patient Signature   Date

_____
Witness Signature

The above release is given on behalf of _____ because the patient is a minor and has been determined to be incompetent to give medical consent.

_____   _____
Parent or Legal Guardian   Date

_____   _____
Relationship to Patient   Witness Signature