Community First Health Centers

Improving the quality of life for our community.

Telehealth Informed Consent Form

I, _____, consent to participate in telehealth services with Community First Health Centers as part of my therapy process and treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth may be provided through secure video, audio, telephone, or other approved electronic communication methods.

By signing this consent, I acknowledge that I understand the following:

1. I have the right to withhold or withdraw my consent for telehealth services at any time without affecting my right to future care or treatment, or my eligibility for program benefits.

2. The privacy protections that apply to in-person services also apply to telehealth. I understand that Community First Health Centers uses reasonable safeguards to protect my privacy and confidentiality, but no electronic communication system is completely risk-free. I understand that telehealth may involve technical problems such as dropped calls, delayed audio or video, poor sound or image quality, or loss of connection.

3. I understand that telehealth may not be appropriate for every situation. Certain emergencies or crises are not appropriate for telehealth services. If I am in crisis or in an emergency, I will call 911 or go to the nearest emergency room or crisis center. I may also call or text 988 for the Suicide & Crisis Lifeline.

4. My provider has explained how the telehealth technology will work, including the expected benefits, limitations, and possible risks. I have been given the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

5. If I cannot connect for a scheduled telehealth visit, I will follow the instructions provided by my therapist or clinic staff regarding how to reconnect or reschedule.

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Patient Signature	Date
Witness Signature	Date
Therapist Signature	Date