ST. JOSEPH'S CHILDREN'S HOME
P.O. Box 1117 (307) 532-4197 (307)532-5921 Torrington, WY 82240
Fax: (307) 532-8405 or (307) 532-4024

INFORMED CONSENT FOR TELEHEALTH CONSULTATIONS

For convenience and cost-efficiency, behavioral health care services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as "telemedicine" or "telehealth," this means that you may be evaluated and treated by a health care provider, specialist or a licensed therapist from a different location. St. Joseph's contracts for psychiatry services provided by a Board Certified or Board Eligible Psychiatrist. Psychiatric and therapy services are provided on St. Joseph's campus and through telehealth communication. Since this is different than the type of consultation with which you are familiar, you must certify that you understand and agree to the following:

1. The consulting health care provider, specialist ("Specialist") or licensed therapist will be at a different location from me. A physician or other health care provider ("Presenting Practitioner") will be at my location with me to assist in the consultation.
2. The Presenting Practitioner may transmit or share electronically details of my medical history, examinations, x-rays, tests, photographs or other images with the specialist who is at a different location.
3. Details of my medical history, examinations, medications, x-rays, and tests will be discussed with the specialist who is at a different location.
4. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the consultant and Presenting Practitioner. I will give my verbal permission prior to additional personnel being present.
5. Video recordings may be taken of the telehealth consultation, after I have given my written permission prior to recording.
6. The Presenting Practitioner for whom the on-site examination or treatment is performed will keep a record of the consultation in my medical record. The Specialist or Licensed Therapist shall also keep a record of the consultation.

N0ting all the above, I understand that my participation in the process described (called "telemedicine" or "telehealth") is voluntary.

RELEASE OF INFORMATION: All existing laws regarding access to your medical information and copies of your medical records, including the Health Insurance Portability and Accountability Act (HIPAA) and apply to this telehealth consultation. Additionally, dissemination of any patient identifiable images or information from this telehealth interaction to researchers or other entities shall not occur without your consent.

I further understand that I have the right to:

1. Refuse the telehealth consultation, or stop participation in the telehealth consultation at any time.
2. Limit any physical examination proposed during the telehealth consultation.
3. Request that the Presenting Practitioner refrain from transmitting my information if I make the request before the information is transmitted
4. Request that nonmedical personnel leave the room(s) at any time.
5. Request that all personnel leave the room(s) to allow a private consultation with the off•site specialist(s).

I acknowledge that the health care providers involved have explained the consultations in a satisfactory manner and that all questions that have asked about the consultations have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

_____ _____
Child's Name DOB

_____ _____
Parent/Guardian Signature Date

_____
Relationship

An exact copy of this release is as valid as the original.
SIGNATURE REQUIRED

Upon completion of documents please email to jgaul@stjoseph-wy.org
or fax to 307-532-8405.