CONFIDENTIAL PATIENT INFORMATION
Cal. W&I code, § 5328
42 CFR Part 2, 45 CFR Parts 160 & 164

ORANGE COUNTY HEALTH CARE AGENCY
BEHAVIORAL HEALTH SERVICES
INFORMED CONSENT FOR SERVICES and TELEHEALTH CONSENT

Informed Consent for Services

In accordance with existing law, the following has been explained to me: the nature and purpose of the proposed evaluation (may include psychological testing), the nature of psychotherapy, alternative therapies, and other treatment methods including the alternative of no treatment, and I understand the risks involved. I consent to the following services being provided, as needed for my health and well-being, either in-person or via telehealth:

1. Assessment
2. Plan Development
3. Psychosocial Rehabilitation
4. Individual Counseling or Therapy
5. Group Education or Therapy
6. Medication Support
7. Targeted Case Management (e.g., referrals, linkage)
8. Peer Services
9. Monitored screening for substances and other drugs that affect my health and well-being

I understand that participation in the Drug Medi-Cal Organized Delivery Systems (DMC-ODS) or the Mental Health Plan (MHP) is voluntary and shall not be considered a prerequisite for access to other community services.

I understand that the above services may be rendered to me in-person or via telehealth, when available and deemed appropriate by my provider.

Telehealth involves the use of synchronous audio-only or synchronous video to interact with me, consult with my healthcare provider and/or review my medical and behavioral health information for the purpose of diagnosis, services, as above, follow-up and/or education. During telehealth services, details of my medical and behavioral health history and personal health information may be discussed with me and/or other health professionals through telecommunications technology.

The potential risk of telehealth services is that there could be a partial or complete failure of the equipment being used which could result in behavioral health staff's inability to complete behavioral health services. Another potential risk of telehealth could be that because of my specific behavioral health condition, or due to technical problems, an in-person consultation may still be necessary after the telehealth appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of privacy. The alternative to telehealth would be an in-person appointment.

I understand the following with regards to participating in telehealth services:

- I have the right to access services in-person or through telehealth (when available and clinically appropriate)
- Use of telehealth is voluntary, and I may withdraw consent for the use of telehealth any time without affecting my ability to access Medi-Cal covered services in the future
- Non-medical transportation services are available to access in-person services when other available resources have been reasonably exhausted
- Translation services are available, if needed

- I must be in the state of California at the time the telehealth service is rendered
- There is no permanent video or voice recording kept of telehealth and telephonic services sessions.
- All existing confidentiality protections under federal and California law apply to information used or disclosed during telehealth and telephonic services.
- I understand I have the right to all confidentiality protections whether services are delivered to me in person, via telephone, or telehealth.
- I understand I have a right to access and copies of all transmitted medical/mental health information.
- There shall be no dissemination of any images or information to other entities without further written consent and an Authorization to Disclose (ATD) Protected Health Information (PHI).
- I understand that I am fully responsible for any costs including overage charges on my phone and/or data plan associated with receiving telehealth and/or telephonic services.

If I am a Medi-Cal member (Orange MHP and/or DMC-ODS), I understand that I retain the right to request other Medi-Cal, Short Doyle/Medi-Cal or Specialty Mental Health reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.

I may be contacted after my participation in the program has ended to evaluate my progress and condition. I understand that I may choose not to answer any questions at that time if I do not wish to do so.

I am satisfied that I have received all the information I need to make an informed decision about in-person and telehealth services. The risks, benefits, and consequences of treatment services have been explained to me. I have had an opportunity to ask questions about this information and all of my questions have been answered. I certify that I have read, understand, and agree with the above and will receive a copy of this consent form. In an emergency situation, I will be provided a copy of this consent as soon as is feasible, via mail, or in-person.

By signing below, I consent to Behavioral Health Services.
☐ However, I DO NOT consent to receiving services through Telehealth at this time (check only if declining).

Member / Participant Name

Member / Participant Signature | Date

Responsible Party / Representative Name | Relationship to Member

Responsible Party / Representative Signature | Date

Provider / Witness Signature | Date

This form was translated to the Member / Responsible Party by (Name) | Translated Language