Connecting to Care

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REFERRAL TO BEHAVIORAL HEALTH SERVICES VIA TELEBEHAVIORAL HEALTH OR FACE-TO-FACE CONSULTATIONS

Patient Name _____DOB:_____

Patient Address: _____

City/State/Zip: _____Phone:_____

Legal Guardian _____DOB:_____

Patient Address: _____

City/State/Zip: _____Phone:_____

Current Physician Name & Location/Clinic:_____

_____

Medical Diagnosis or Conditions, Psychiatric Diagnosis, Current Medications, or Substance Abuse:

_____

_____

Describe concern/reason for referral: _____

_____

Preference for Behavioral Health: ☐Male ☐Female ☐No Preference (Check One)

Please indicate your preference: ☐ Initial consultation, ☐ On-going behavioral therapy ☐ Both (Check One)

CONNECTING TO CARE

Authorization for Use or Release of Information for Participation in Behavioral Health Services
Via TeleBehavioral Health or Face-to-Face Consultations
Consent and Authorization to Disclose, Exchange and Use Information and Records

I, **Patient Name:** _____ as a participant in Behavioral Health Services, via TeleBehavioral Health or Face-to-Face Consultations, authorize the use of, to disclose, and exchange, verbally and in writing, information about me for the purpose of collaborating, coordinating, and facilitating services and treatment. I authorize the release, disclosure, and exchange of health information as follows: Name and other personal identifying information, Evaluations and assessments of status and progress, summaries of history, treatment and results, and if requested, Mental Health Assessment and Treatment, Alcohol and Drug Treatment, Medical treatment records

I understand my right to refuse to sign this authorization. My refusal to sign this form will not affect my ability to receive services from my health care providers, but I may not be able to receive the benefits of participation in Behavioral Health Services. I release the source of these records from any liability arising as a result of the exchange of the records. I understand this authorization is effective immediately and subject to revocation at any time for any reason except to the extent action has already been taken. I understand I have a right to receive a copy of this authorization.

Liability Waiver / Release of All Claims

1. As lawful consideration for being permitted to participate in Connecting to Care Behavioral Health Services, I agree that I will not make a claim against, sue, attach the property of or prosecute Connecting to Care and its agents, affiliates and employees for damages for death, personal injury or property damage which I may sustain as a result of my participation in these telemedicine services. This release is intended to discharge in advance Connecting to Care, its agents, affiliates and employees from and against any and all liability, including negligent actions, arising out of or connected in any way with my participation in Behavioral Health Services, except for liability that may arise out of the willful or wanton misconduct of Connecting to Care and its agents, affiliates and employees.
2. I further understand that Connecting to Care is not providing any clinical or medical services and that Behavioral Health Services involves the electronic transmission of data that is susceptible to technical difficulties and errors that may impact the quality and integrity of data transmitted via the telemedicine services and such technical difficulties and data integrity errors may, directly or indirectly, result in serious personal injuries (including death) and/or property damage, as a consequence thereof. Knowing the risks of participation, nevertheless, I hereby agree to assume those risks and to release and hold harmless Connecting to Care and its agents, affiliates and employees who (through negligence or carelessness), might otherwise be liable to me (or my heirs or assigns) for damages.
3. I have carefully read this agreement and fully understand its contents. I am aware that this is a release of liability and a contract between myself and Connecting to Care and its agents, affiliates and employees, and I have signed it of my own free will.

I attest that I am eighteen (18) years old or older; or I am the duly authorized legal representative of the participant in Connecting to Care Behavioral Health Services, via TeleBehavioral Health or Face-to-Face Consultations.

Signature of Patient or legal Guardian:_____ **Date:**_____

CONNECTING TO CARE

Consent and Authorization to Participate in Behavioral Health Services
Via TeleBehavioral Health or Face-to-Face Consultations

PATIENT/CLIENT _____DOB_____

PURPOSE: The purpose of this form is to obtain your consent and authorization to participate in Connecting to Care's Behavioral Health Services via TeleBehavioral Health or Face-to-Face Consultations.

NATURE OF BEHAVIORAL HEALTH CONSULTATION: TeleBehavioral Health involves the use of audio, video, or other electronic communications to interact with you, consult with your health care provider and/or review your medical and mental health information for the purpose of diagnosis, treatment, follow-up and/or education. During your Behavioral Health Consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recording may be taken. Also, non-medical technical personnel may participate in the TeleBehavioral Health consultation to aid in the audio/video link.

RISK, BENEFIT AND ALTERNATIVES: The benefits of TeleBehavioral Health include having access to medical specialists and additional medical information and education without having to travel outside of your local health care community. A potential risk of TeleBehavioral Health is that because of your specific health condition or due to technical problems, a Face-to-Face consultation may still be necessary after the TeleBehavioral Health appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to TeleBehavioral Health consultation is a Face-to-Face visit with a health care provider.

MEDICAL INFORMATION AND RECORDS: All laws concerning patient access to medical records and copies of medical records apply to Behavioral Health Services. Dissemination of any patient identifiable images or information from the consultation to researchers or other entities shall not occur without your consent.

CONFIDENTIALITY: All existing confidentiality protections under federal and California law apply to information used or disclosed during your participation in Behavioral Health Services.

RIGHTS: You may withhold or withdraw your consent to participate in Behavioral Health Services at any time before and/or during the consult without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

My health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agreed to this Consent and Authorization to Participate in Behavioral Health Services via TeleBehavioral Health or Face-to-Face Consultations:

Signature of Patient/Client_____ or,

Signature of Patient/Client's Representative_____

Relationship _____

Signature of Witness if Patient/Client Unable to Sign_____

Printed Name of Witness _____

Date of Signature _____