Lutheran Services Florida Child Welfare Case Management Informed Consent for Tele-Visits

Client: _____ D.O.B._____ SSN: _____

I,_____, hereby voluntarily consent to engage in tele-visits. Tele-visits is a form of therapy provided via internet technology, which can include consultation, treatment, transfer of protected health information, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that tele-visits involves the communication of my medical/mental health information, both orally and/or visually.

Limitations on Confidentiality

Tele-visits has the same purpose or intention as case management services that are conducted in person. However, due to the nature of the technology used, I understand that tele-visits may be experienced somewhat differently than face-to-face services.

I understand that I have the following rights with respect to tele-visits:

Client's Rights, Risks, and Responsibilities:

1. I, the client/legal guardian of client, need to be a resident of Florida.
2. The laws that protect the confidentiality of my medical information also apply to tele-visits. As such, I understand that the information disclosed by me during the course of my case management services is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which have been described to me.
3. I understand that there are risks and consequences of participating in tele-visits, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my case manager, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons.
4. There is a risk that services could be disrupted or distorted by unforeseen technical problems. In addition, I understand that tele-visits based services and care may not be as complete as face-to-face services.
5. I understand that I may benefit from tele-visits, but that results cannot be guaranteed or assured.
6. I accept that tele-visits do not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.
7. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in tele-visits. I am responsible for:
    - Providing the necessary computer, telecommunications equipment and internet access for my tele-visits sessions.

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- Arranging a location with sufficient lighting and privacy that is free from distractionsor intrusions for my tele-visits session.
- It is the responsibility of the case management organization to do the same on their end.

Legal Guardian (if child is client)

I,_____, do hereby state that I am the natural parent or legal guardian of the client; therefore, I am authorized to make this request for and give my legal consent to the services mentioned in this form.

_____ _____

Client/Guardian Date

_____ _____

Witness Signature Date