
Vinder Lallian, MA

Licensed Marriage and Family Therapist, CA Licensed #MFC 52026

2540 Douglas Blvd. Suite 200, Roseville, CA 95661

Telehealth Informed Consent Form

I, _____ (patient name) hereby consent to engaging in telehealth with Vinder Lallian, Licensed Marriage and Family Therapist. I understand that “telehealth” includes the practice of education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

I understand that I have the following rights with respect to telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental and emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.

3. I understand that there are risks and consequences from telehealth, including, but limited to, the possibility, despite reasonable efforts on the part of my psychotherapist,

that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by authorized persons.

In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face to face services) I will be referred to a psychotherapist who can provide such services in my area.

Finally, I understand that there are potential risk and benefits associated with any form of psychotherapy, and that despite my efforts and efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

1. I understand that I may benefit from telehealth, but the results cannot be guaranteed or assured.
2. I understand that I have a right to access my medical information and copies of medical records in accordance with California law.
3. I have signed an agreement for services that explains traditional face-to-face services.

I have read and understood the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Print name of patient/parent/guardian/conservator

Date

Signature of patient/parent/guardian/conservator

Date