

**CHILD AND ADOLESCENT MOOD AND ANXIETY TREATMENT PROGRAM
INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY VIA
TELEHEALTH**

Psychological Evaluation and Treatment of Children and Adolescents, Protocol #20130139

The purpose of this document is to obtain consent for Telehealth Services with the University of Miami Child and Adolescent Mood and Anxiety Treatment (CAMAT) Program. Telehealth service is the delivery of healthcare services when the therapist and patient are not in the same physical location/site through the use of various technology. Information provided may be used for diagnosis, therapy, follow-up and/or education, and may include any combination of the following: (1) client records; (2) live two-way audio and video; (3) interactive audio; and (4) output data from sound and video files.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification, identifiable materials, and the data and to ensure its integrity against intentional or unintentional corruption.

Since this may be different than the type of consultation with which you are familiar, it is important that you understand, acknowledge and agree to the following statements:

- I understand that I have undertaken to engage in a telehealth encounter for myself and my child that will contain personal identifying information as well as protected health information, as well as audio and/or video recordings of sessions.
- I understand that the consulting therapist/provider will be at a different location from me.
- I voluntarily consent to healthcare services provided which may include review of diagnostic assessments, therapy sessions, and consultation on recommendations considered necessary for treatment.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth services at any time in the course of my care, without affecting my right to future care or treatment.
- I have been informed of and accept the potential risks associated with telehealth, such as failure of security protocols that may cause a breach of privacy of personal and/or medical information.
- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to other entities without my consent or as may be allowed by law.

- I understand that using a form of communication technology other than approved University of Miami telehealth communications may compromise security protocols or cause information transmitted to be insufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the consulting healthcare provider. I understand that such communications may not be included as part of my chart or my medical record.
- I have been given the opportunity to ask the University of Miami questions relative to my Telehealth encounter, security practices, technical specifications, and other related risks.

By signing this form, I certify:

- That I have read or had read and/or had this form explained to me;
- That I fully understand its contents including the risks and benefits of telehealth services; and
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature of Parent or Guardian

Date

Printed name of Parent or Guardian

Name of Child