SAN BERNARDINO COUNTY
Behavioral Health

303 E. Vanderbilt Way, San Bernardino | (909) 388-0900
www.SBCounty.gov

TELEHEALTH CONSENT FORM

I agree to receive health care services via telehealth. I understand that:

a. I have the right to access Medi-Cal covered services through an in-person, face-to-face visit or through telehealth.

b. The use of telehealth is voluntary, and I may withdraw my consent to, or stop receiving services through telehealth at any time without affecting my ability to access covered services in the future.

c. Medi-Cal provides coverage for transportation services to in-person services when other resources have been reasonably exhausted.

There may be limitations or risks related to receiving services through telehealth as compared to an in-person visit. For example technical glitches, disconnection, compromised privacy/security, etc.

I have read this document carefully, understand the potential limitations and risks of receiving services via telehealth, and have had my questions answered to my satisfaction.

Client: (print) _____ (sign) _____ Date: _____

Witness: (print) _____ (sign) _____ Date: _____

Parent/Guardian/
Conservator: (print) _____ (sign) _____ Date: _____