Atlanta Intervention Network

TELE-HEALTH CLINICAL EVALUTION CONSENT FORM

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a Tele-Health clinical evaluation under O.C.G.A. 40-5-63.1 or O.C.G.A.40-6-391 to diagnose an individual's substance abuse or dependence and, if indicated, to refer the individual to appropriate treatment.
2. PERSONAL INFORMATION AND RECORDS: Clinical Evaluators (CE) must inform clients about their responsibilities regarding maintaining confidentiality, including legally reporting situations, and the potential risks to confidentiality when using technology. Clinical Evaluators must notify clients as soon as possible of any breach of confidentiality as a result of electronic transmission of confidential information, and document in the client file.
3. RIGHTS: You may withhold or withdraw consent to the Tele-Health at any time without affecting your right to a future clinical evaluation, or risking the loss to benefit to which you would otherwise be entitled.
4. DISPUTES: You agree that any dispute arriving from the Tele-Health clinical evaluation will be resolved in Georgia, and that Georgia law and DBHDD DUIIP rules & regulations shall apply to all disputes.
5. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of Tele-Health clinical evaluations. Your CE has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the Tele-Health clinical evaluation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a Tele-Health clinical evaluation for the procedure(s) described above.

Client Signature: _____

DATE: _____

CE Signature: _____

DATE: _____