VIRTUAL RAPID ACCESS ASSESSMENT CONSENT & PATIENT ADVOCATE AUTHORIZATION

Purpose of Assessment

I understand that I am participating in a virtual behavioral health assessment to evaluate my mental health needs, level of risk, and recommended level of care.

_____ Initial

Consent for Telehealth Services

I acknowledge and agree to the following:

- I consent to participate in a behavioral health assessment conducted via telehealth (video or audio-visual communication).
- I understand that telehealth involves the use of electronic communications to share medical information and that it may have limitations compared to in-person evaluations.
- I understand that I may discontinue or refuse the telehealth session at any time.
- I agree to participate in the telehealth visit in a private and safe location free of distractions as much as possible.
- I understand that my confidentiality is protected under federal and state law, and electronic communications will be safeguarded to the extent that is reasonably possible.

_____ Initial

Consent to Have a Patient Advocate Present

I authorize the individual listed below as my Patient Advocate to be present during my virtual assessment.

I understand and consent to the following:

- The Patient Advocate may hear all information shared during the assessment.
- The Patient Advocate may participate by providing collateral information as requested by the clinician.

- The Patient Advocate will receive the clinician's recommendations at the conclusion of the assessment, including but not limited to:
  - Suggested level of care
  - Safety plan information

I understand that discussed information may include sensitive mental health, medical, risk-related, or personal information, and I consent to share this information with the Patient Advocate.

_____ Initial

Patient Advocate Responsibilities

By signing below, the Patient Advocate acknowledges and agrees to the following responsibilities:

- To remain present and attentive during the assessment, unless otherwise directed by the clinician.
- To receive and understand the recommendations given by the mental health professional.
- If the clinician recommends an in-person emergency evaluation, the Patient Advocate agrees to transport the patient to the nearest designated emergency receiving facility or call emergency services (911) if transportation is not safe or feasible.
- To support the patient in following the recommended plan of care.
- To respect the patient's privacy and confidentiality.

Limitations of Telehealth & Emergency Procedures

I understand that:

- A virtual assessment may have limitations in evaluating risk or symptoms.
- If the clinician determines that I am at risk of harm to myself or others, or unable to maintain my safety, the clinician may:
  - Recommend immediate in-person evaluation
  - Contact emergency services

- Notify the Patient Advocate or emergency contact listed below
- I agree to comply with safety recommendations.

_____ Initial

Consent & Acknowledgment

By signing this form, I acknowledge that:

- I have read or had this form explained to me.
- I understand the nature, purpose, and potential risks of telehealth services.
- I agree to the presence and involvement of the Patient Advocate as described above.
- All questions have been answered to my satisfaction.

_____ Initial

PATIENT INFORMATION & SIGNATURE

Patient Name: _____

Date of Birth: ____ / ____ / _____

Phone: _____

Location During Assessment (Address Required):

Patient Signature: _____ Date: ____ / ____ / _____

PATIENT ADVOCATE INFORMATION & SIGNATURE

Advocate Name: _____

Relationship to Patient: _____

Phone: _____

Alternate Phone: _____

Address: _____

I agree to the responsibilities outlined above, including transporting the patient to an emergency receiving facility if recommended by the clinician.

Patient Advocate Signature: _____ Date: ____ / ____ / _____