TELEHEALTH EMAIL ACKNOWLEDGEMENT FORM

The undersigned beneficiary/client* or responsible party** acknowledges/authorizes Orange County Health Care Agency (OCHCA) Behavioral Health Services (BHS) Mental Health Plan (MHP) and Substance Use Disorder (SUD) / Drug Medi-Cal Organized Delivery System (DMC-ODS) County Operated providers at:

_____
(Name of Facility and/or Program)

to use email to communicate with me for the following purposes:

- Scheduling Telehealth appointments
- Sending reminders of Telehealth appointments

The undersigned beneficiary/client understands:

1. Email should never be used for emergency purposes. The email system does not have a 24-hour monitoring service nor can the system guarantee delivery of email messages in a timely manner. If you are having a psychiatric emergency please call the Crisis Assessment Team (CAT) at 866.830.6011. If this is a life threatening emergency, please call 911 or go to the nearest hospital emergency department.
2. Acknowledging/Authorizing the use of email is at the beneficiary/client request.
3. Email will never be used for diagnostic or treatment purposes and requests to be assessed or treated through email will not be honored.
4. Email is not an instant messaging system. I understand I will NOT receive a response if I send an email.
5. By signing this acknowledgement, I agree to allow OCHCA BHS MHP and SUD/DMC-ODS County Operated providers to send Telehealth appointment information to me via email.
6. The ability to use email may be rescinded by me or my OCHCA BHS MHP and SUD/DMC-ODS County Operated Provider at any point if I or my OCHCA BHS MHP and SUD/DMC-ODS believe email is not the most appropriate means of communication for me.
7. Any unauthorized use of email should be reported to my OCHCA BHS MHP and SUD/DMC-ODS County Operated Provider as soon as possible.
8. Although OCHCA will not be sending any confidential information via email, there is a risk that an email intended for me may be inadvertently sent to the wrong email address. I understand this risk.

I have read this document carefully and understand the above information. By signing below, I acknowledge and authorize use of email for the purposes described above.

First and Last Name of Beneficiary/Client	Signature of Beneficiary/Client*	**Email Address**	Date
First and Last Name of Responsible Party**	Signature of Responsible Party**	Relationship to Beneficiary	Date

This form was interpreted by_____(name of interpreter) in _____(language) for the beneficiary/client and/or responsible party.

If a translated version of this form was signed by the beneficiary and/or responsible party, the translated version must be attached to the English version.

The above information including email address has been confirmed to be legible by _____
First & Last Name of Orange MHP Provider

Beneficiary ☐ was given / ☐ declined a copy of this form on _____ (Date) by _____ (Provider Initials).

This section must be completed by the Provider if consent is withdrawn.

☐ Beneficiary/Client had previously provided authorization but now wishes to withdraw authorization as of_____(date)

First and Last Name of Orange MHP Provider	Signature of Orange MHP Provider	Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the beneficiary/client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

*A minor receiving services under his/her own signature must have the signed Consent of Minor form on file in the clinical record.
**Responsible Party = Guardian, Conservator, or Parent of beneficiary/client when required.