Revoked On: Staff Initials:

NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

CONSENT TO THE USE OF TELEPRACTICE IN THE PROVISION OF ADDICTIONS TREATMENT

Patient's Last Name	First Name	M.I.
CASE No.		
FACILITY	UNIT	

INSTRUCTIONS: GIVE COPY OF FORM TO PATIENT. Keep an original of this consent

TELEPRACTICE INFORMED CONSENT

PURPOSE OR NEED FOR CONSENT: To permit the Substance Use Disorder (SUD) treatment to be provided via Telepractice as specified in OASAS Part 830 Regulations.

EXTENT OR NATURE OF INFORMATION

I_____provided information and understand the following regarding services delivered via Telepractice:

I. Description:

Telepractice is the delivery of Substance Use Disorder (SUD) treatment services provided by an OASAS certified program who is approved for the provision of Telepractice via Audio/Visual and when approved Telephonic mediums. Telepractice is a method of obtaining treatment and recovery support when in-person methods are not available and is subject to the same regulatory and clinical standards as in-person services. When applicable, reimbursable through both Medicaid and Commercial Insurance Plans.

II. Confidentiality:

Telepractice is subject to the confidentiality requirements of 42 CFR Section and HIPAA for the protection of individual's privacy and confidentiality while providing services via Telepractice. Telepractice should be delivered using telecommunication technology that is compliant with confidentiality standards of state and federal law. Provider using Telepractice will make every reasonable effort to decrease the risks associated with the use of Telepractice. I further understand that my confidential information will not be redisclosed without my consent.

III. Patient Rights:

Telepractice is also subject to the requirements of the OASAS Part 815 Patient Rights Regulations. Concerns regarding my treatment can be sent to PatientAdvocacy@oasas.ny.gov I understand that I can decline services via Telepractice at any time.

I, the undersigned, have read the above and authorize the staff of _____, to provide my SUD treatment services via Telepractice. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it, and that in any event this consent expires automatically as follows:

_____

(Signature of Patient) (Signature of Parent/Guardian, when required)

(Print Name of Patient) (Print Name of Parent/Guardian)

(Date) (Date)

Describe authority to sign on behalf of Patient: