|  |  |
| --- | --- |
| **Person Served Name:** | **Avatar ID Number:** |

I understand that I have the right to access covered substance use disorder (SUD) services through an in-person, face-to-face visit or through telehealth (synchronous audio or video) or telephone. If a service is provided through telehealth or telephone, the SUD provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable SUD services via telehealth.

I understand that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time without affecting the ability to access covered Drug Medi-Cal services in the future. I further understand the availability of Drug Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.

I have been given an opportunity to read this form and ask questions about its contents and provisions. I freely give my consent for SUD services to be provided by the Fresno County Department of Behavioral Health (directly operated programs and contract agencies) through telehealth (synchronous audio or video) or telephone. I further understand that I can withdraw this telehealth consent and stop receiving SUD services via telehealth at any time.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| X |  | |  | |  | |
| Printed Name and Signature of person served/parent/conservator/legal representative\* | | |  | | Date | |
| **If signed by someone other than the person served, please state your legal relationship to the person served:** | | | | | | |
|  | | | | | | |
| X |  | | |  | |  |
| Printed Name and Signature of witness/Interpreter\*\* | | | |  | | Date |
| X |  | | |  | |  |
| Printed Name and Signature of witness\*\*\* | |  | |  | | Date |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A copy of this Consent | [Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.] | Was given/offered | [Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.] | Was declined |  | On |  | by |  |
| **Revocation:** |  |  |  |  |  |  | Date |  | Staff Name |
| I revoke this SUD telehealth consent. | | |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  | Date |  | Signature |
| Verbally revoked this SUD telehealth consent on. | | |  |  |  |  |  |  |  |