CONSENT FOR SECURE TEXT MESSAGING / VIDEO CHAT

Secure Text Messaging and Video Chat Information

What is Secure Text Messaging/Video Chat?

Secure Text Messaging/Video Chat involves the use of a Los Angeles County Department of Mental Health (DMH) - approved text messaging and video chat application that allows authorized DMH providers to securely send and receive encrypted pictures, exchange text, audio and video messages securely, and conduct secure video conferences with clients. This method is secure, encrypted, and compliant with all laws related to the protection/security of Protected Health Information (PHI).

How can Secure Text Messaging/Video Chat be beneficial?

Secure text messaging/video chat allows clients and an authorized DMH mental health provider to quickly and efficiently communicate by sending and receiving text messages and video chats. The use of secure text messaging provides another avenue for clients to communicate with mental health providers should both parties decide that secure text messaging is an appropriate method of communication.

What happens if I choose not to consent to using LACDMH's Secure Texting Messaging / Video Chat Application?

Without the consent for using the DMH-approved secure text messaging/video chat application, DMH workforce members will not initiate text messaging with clients or offer text messaging to clients as a mode of communication. If a client initiates text messaging with a DMH workforce member, staff will respond to the client via other means of communication (e.g. telephone call or mail).

MH 732
3/8/19

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The undersigned understands:

1. Secure Text Messaging/Video Chat should not be used for emergency or urgent situations. The undersigned should discuss how to best contact the provider after normal business hours or during any emergency or urgent situation.
2. It is important for the undersigned to keep one's mental health provider informed of current contact information should it change at any time.
3. Consenting to the use of Secure Text Messaging/Video Chat is at the undersigned's request.
4. Secure Text Messaging/Video Chat will never be used for diagnostic purposes and requests to be assessed through either method will not be honored.
5. The LACDMH Approved Secure Text Messaging / Video Chat Application is the only option for sending and receiving texts and video chat with LACDMH Workforce Members.
6. LACDMH assumes no liability for the undersigned's cellular device. If installation of the LACDMH Approved Secure Text Messaging / Video Chat Application causes any conflict, malfunction, or damage, LACDMH will not be held responsible.
7. The undersigned is fully responsible for the handling, operating, and maintaining of his/her cellular device as well as any applications and information including but not limited to Protected Health Information (PHI). Should the undersigned's device be compromised, lost, or stolen, LACDMH will not be held responsible for the disclosure of information which was residing on the device at the time of or after the incident.
8. The undersigned is responsible for contacting his/her cell phone provider regarding any data usage or texting fees as a result of using Secure Text Messaging/Video Chat.
9. The undersigned has the option to withhold or withdraw consent at any time, without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which the undersigned would otherwise be entitled. This consent may also be revoked by the provider at any time.

I, ________________________________, consent to using the LACDMH Secure Text Messaging / Video Chat Application with ________________________________. My mental health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I understand the information provided above.

Signature of Client*	Phone number for text messaging	Date
Signature of Responsible Adult**	Relationship to Client	Date
Signature of Witness/Interpreter ***		Date
Signature of Authorized Workforce Member		Date

This Consent was interpreted in ____________________ for the client and/or responsible adult.
If a translated version of this Consent was signed by the client and/or responsible adult, the translated version must be attached to the English version.

Signature ☐ was given ☐ declined a copy of this Consent on ______________ (Date) by ________ (Initials).

This section must be completed by Staff if consent is withdrawn.

☐ Client had previously provided Consent but now wishes to withdraw Consent as of _____________ (date)

First Name and Last Name of Staff	Signature of Staff	Date

* A minor client receiving services under his/her own signature must have the signed Consent of Minor form on file in the clinical record.
** Responsible Adult = Guardian, Conservator, or Parent of minor when required.
*** Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language it was interpreted into).

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 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.

Name: **ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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