

# Consent for AI-Assisted Documentation

Mental health care | Patient authorization for the specific use described below

**Patient name**

**Date of birth**

**Clinician / practice**

**AI tool / vendor**

**Clinician:** Complete all details below and discuss this form before using the tool.

**Capture method (check all that apply):**

☐ Audio

☐ Transcript

☐ Clinician-entered notes

**Other information processed**

**Who receives / processes the information**

**Audio / transcript retention and deletion**

**Other data retention / deletion; privacy notice location**

# Your choices and authorization

Review with your clinician. Ask questions before making your choice.

**1. Purpose and clinician responsibility.** This tool helps draft clinical documentation. It may make errors, omit information, or generate inaccurate content. My clinician will review and edit its output before finalizing my record and remains responsible for my care. This consent does not authorize independent AI diagnosis, treatment, or prescribing.

**2. Privacy and limits.** The information identified above will be processed by the listed tool and recipients. Potential risks include unauthorized access, disclosure, and inaccurate documentation. No system can guarantee complete confidentiality. This consent does not authorize advertising, sale of my information, or AI model training. Any such use requires a separate lawful basis and, where applicable, separate authorization.

**3. My choices.** Participation is voluntary. I may decline, request that capture be paused, or withdraw consent by telling my clinician. My clinician will use an alternative documentation method without affecting my access to care. Withdrawal stops future use; it does not remove finalized clinical records or necessarily reverse processing already completed. My clinician has explained applicable retention and deletion limits.

**4. Scope and questions.** This form applies only to the documentation use described above. A material change in tool, purpose, capture, or data practices will be explained and consent revisited before that change is used. I had an opportunity to ask questions and understand the benefits, risks, and alternatives.

**My choice (select one):**

☐ I consent to the described use.

☐ I decline.

Patient / authorized representative signature

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Date:

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Representative name and authority (if applicable)

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Clinician signature

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Date:

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**Practice template:** Adapt to actual vendor practices, applicable law, and professional requirements before use.