Telehealth Informed Consent

Telehealth allows my therapist to diagnose, consult, treat, and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as telehealth).

I understand I have the following rights under this agreement; I have a right to confidentiality with telehealth under the same HIPAA privacy laws that protect the confidentiality of my health information for face-to-face psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards myself or a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger and alert the appropriate party.

I understand that the dissemination of any personally identifiable images or information from the telehealth interaction to any other entities shall not occur without my written consent. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted/accessed by unauthorized persons.

In addition, I understand that telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information directly with my therapist and to have any questions answered to my satisfaction. I understand that I can withdraw my consent to telehealth communications by providing written notification to my therapist. My signature below indicates that I have read and agree to this agreement and its terms.

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Signature of Client Date

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Signature of Parent or Legal Guardian Date