



Trauma Informed Therapies, PLLC  
A Refuge: Trauma Informed Therapies

**Consent for Telehealth Services**

I consent to engaging in telehealth as part of my treatment. I understand that “telehealth” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of personal health information, and education using interactive audio, video, or data communications.

**I understand that I have the following rights with respect to telehealth:**

- I have the right to withhold or withdraw this consent at any time. However, if I do so, this may require my therapist to provide referrals to other treatment providers, if face-to-face services are not an option based on geography and/or circumstance.
- The laws that protect the confidentiality of my personal health information also apply to telehealth, as do the limitations to that confidentiality discussed in the Services Agreement. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction will not be shared without my written consent.

**I understand that there are unique risks and consequences with telehealth, despite reasonable efforts on the part of my therapist to avoid them. These potentially include:**

- Transmission of my personal health information could be disrupted or distorted by technical failures
- Transmission of my personal health information could be interrupted by unauthorized persons
- Electronic storage of my personal health information could be accessed by unauthorized persons.

I understand I may be requested to install applications specific to treatment onto my phone, tablet or computer device. Some applications specifically interact via phone / tablet, device, etc. and have the capability to report activity, gps location, etc.

**In addition, I understand that telehealth based services may not be appropriate for everyone seeking therapy. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a practitioner who can provide such services in my area.**

**I understand that this form is signed in addition to the Services Agreement, and that all policies and procedures within the Services Agreement apply to telehealth services.**

I have read and understand the information provided above. I have discussed it with my therapist, and all of my questions have been answered to my satisfaction.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_