Trauma Informed Therapies

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10. TELEHEALTH CONSENT FORM

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 Signature (if applicable):

Date (if applicable):