Telehealth Informed Consent

PATHWAYS THERAPY AND WELLNESS CENTER TELETHERAPY PROGRAM

TELETHERAPY PATIENT CONSENT FORM

Client Name:____________________________________

☐ I agree to participate in teletherapy therapy to include evaluation and on-going treatment. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a therapist and other persons involved in my mental health care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

☐ I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a teletherapy session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation

☐ I understand that therapeutic and/or medical records of teletherapy services will be kept at the referring site facility and any recording of sessions by my therapist or me must be disclosed in writing prior to recording.

☐ I understand that some or all of my therapeutic and/or medical information may be used for supervision and training purposes.

IF YOU DECLINE PLEASE INITIAL BELOW (initials of patient)

☐

Client Signature:________________________________ Date:_____________________