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Lethbridge, AB

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Traumatherapy.solutions

**Client Consent for Counselling Sessions via Zoom**

**Clinic Name:** Trauma Therapy Solutions  
**Counsellor/Therapist:**

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of this Consent**

This form provides information about the use of **Zoom** for counselling sessions and documents your consent to participate in virtual services using this platform.

**Telehealth Platform: Zoom**

Your sessions may be offered through **Zoom**, a secure, encrypted video conferencing platform. The clinic uses **Zoom Pro or Healthcare**, with additional privacy features such as:

* Password-protected sessions
* Waiting room enabled
* No recording of sessions
* End-to-end encryption when supported
* Sessions conducted in a private, secure location by the therapist

**Privacy and Confidentiality**

Your privacy and confidentiality remain a priority. However, the nature of online communication involves some risks beyond the control of the clinic, including:

* Risk of data interception or breaches by third parties
* Potential privacy limitations depending on your location or internet connection
* Reduced control over the confidentiality of your environment (e.g., others overhearing)

To help maintain your privacy:

* Choose a private, quiet space for your session
* Use headphones if others are nearby
* Ensure a secure and stable internet connection
* Do not record the session

**Your Rights**

You have the right to:

* Ask questions about the telehealth process
* Withdraw your consent at any time
* Request in-person sessions (if available)
* Access your health information as outlined in Alberta’s **Health Information Act (HIA)**

**Consent Statement**

☐ I confirm that I understand the risks, benefits, and limitations of using Zoom for counselling sessions.  
☐ I understand that sessions will **not be recorded** by my therapist, and I agree not to record sessions without explicit consent.  
☐ I consent to participate in counselling via Zoom and understand that I can withdraw this consent at any time by notifying my therapist.  
☐ I have had the opportunity to ask questions and have received satisfactory responses.

**Client Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date (of review with client if submitted on-line):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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