**Online Therapy Disclosure**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (client name), hereby consent to engage in Online Therapy (also called by other names, such as Telehealth, Telemedicine, or E-Counseling) with **Sarah Rasche, LCSW, PMH-C** as a delivery method for my psychotherapy treatment. I understand that Online Therapy includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that Online Therapy may involve the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to Online Therapy:

* I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
* The laws that protect the confidentiality of my medical information also apply to Online Therapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See additional Disclosures and HIPAA Notice of Privacy Practices forms, provided to me at intake, for more details of confidentiality and other issues).
* I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.
* I understand that there are risks and consequences from Online Therapy. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.
* In addition, I understand that if my psychotherapist believes I would be better served by another form of mental health service or health care intervention, I may be referred to a health care provider in my area who can provide such service.
* I understand that I may benefit from Online Therapy, but results cannot be guaranteed or assured. The benefits of Online Therapy may include but are not limited to: adhering to current social distancing recommendations in light of COVID-19; maintaining access to therapy; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.
* I understand that I have the right to access my medical information and copies of medical records in accordance with Colorado law, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated.

Please indicate below that you have reviewed and accept the above Online Therapy Disclosure:

Client Name:

Client Signature: Date: