Telehealth Informed Consent Form

I ____ [name of client] hereby consent to engaging in telehealth with Samaritan Counseling Center of Southern Wisconsin as part of my psychotherapy with my therapist there. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of mental health data, and education using interactive audio, video, or data communications.

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

(1) I have the right to withdraw this consent in writing at any time.

(2) The laws that protect the confidentiality of my medical and mental health information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is confidential. However, there is a mandatory exception to confidentiality, regarding the reporting of child, and elder abuse.

(3) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health information could be interrupted by unauthorized persons; and/or limited ability to respond to emergencies.

Additional benefits of telehealth may include: easier and more efficient way to access clinical care; obtain treatment at times that are convenient for you; and ability to interact with your psychotherapist without the necessity of an in-office appointment.

In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that my psychotherapist may determine that my condition is not suitable for treatment using telehealth. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve.

I understand that the delivery of telehealth is an evolving field and the use of telehealth may include uses of technology not specifically described in this consent.

I agree and authorize my psychotherapist to share information with the Samaritan Center for treatment, payment and health care operations as allowed by law.

I have read and understand the information provided above and give my informed consent for the use of telehealth. If I have any further questions, I will discuss them with my psychotherapist during our next session.

____ ____________________

Client Signature **Date**

____ ____________________

Parent/Guardian Signature (if applicable) **Date**

Clients age 14-17 years of age must sign **in addition** to their parent/guardian.