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Healing Relationships Around The Globe

CONSENT FOR TELEHEALTH CONSULTATION

Clients Names: _____

Dates of Birth:_____/_____

Either I or my psychotherapist may desire to take part in a telehealth consultation provided via a two-way audio/video link, for various reasons. I understand that: My psychotherapist and I will meet through a very secure video-conference system.

1. I can ask that the exam and/or audio/video link be stopped at any time.
2. I understand that this procedure will be done through a audio/video platform link using Zoom or some equally secure, safe technology, and the vast majority of clients have found the virtual experience to be equally effective to a face-to-face visit with my health care provider.
3. I understand that there are possible risks with the use of this technology. These include, but are not limited to:
    a. Interruption or disconnection of the audio/video link
    b. A picture that is not clear enough to meet the needs of the consultation.
    c. Zoom Technology meets very high privacy standards, use encryption and is HIPAA compliant. However there is alway a very small chance that data security could be breached. If any of these risks occur, the session might need to be stopped and resumed later at no charge.
4. I understand that any records of this consultation will become part of my medical record kept by the healthcare provider. This consultation may be recorded, but will not be placed in cloud and only in the care of the provider.
5. I understand that I must give my informed consent to participate in this consultation. In signing this document, I provide informed consent.

Signature of Client: _____ Date: _____

Print Name: _____

Signature of Client: _____ Date: _____

Print Name: _____

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