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Tele-mental Health Informed Consent

I, _____, on behalf of _____, hereby consent to participate in tele-mental health with the clinician named below, as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

- 1) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- 2) During telemental health sessions, I (patient or guardian) agree to be in an area that is considered private from other individuals, to ensure my confidentiality. Parent/guardian agrees to provide their child an area to provide privacy and respect their privacy throughout telemental health sessions, unless their participation has been agreed upon by the therapist and child.
- 3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- 4) I understand that the privacy laws that protect the confidentiality of my protected health information also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
- 5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
- 6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, I or the therapist will attempt to end and restart the session. If we are unable to reconnect within 5 minutes, the therapist will call and the therapy session will continue over the telephone.
- 7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency. I understand that if I express a desire to hurt myself or others and I disconnect from the session and cannot be reached, the therapist will call 911.
- 8) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

I understand that I may benefit from telemedicine but that results can vary depending on the individual.

I have read and understand the information provided above. I have discussed it with my counselor and my questions have been answered to my satisfactions. My signature below indicates my informed and willful consent of treatment using this platform.

Patient or Guardian Signature

Date

Provider's name: _____