SouthSHORE
COUNSELING

Telehealth Client Consent Form

Client Name:_____Date:_____

Client Date of Birth:_____

The purpose of this form is to obtain consent to participate in telehealth consultation in connection with mental health/counseling services. During the telehealth consultation, details of your medical and mental health will be discussed with a clinician through the use of audio and video technology. All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Telehealth services are not recorded and dissemination of any patient related information will not occur without your request and consent. Reasonable and appropriate efforts have been made to reduce confidentiality risks associated with telehealth consultation, and all existing confidentiality protections under federal and WI state law continue to apply to information disclosed during this telehealth consultation. We are not able to guarantee complete confidentiality while telehealth services are provided due to the limitations of technology and lack of encrypted services, however, we attempt to conduct services in the most confidential and protected manner available.

You may withhold or withdraw your consent for telehealth services at any time without affecting your right to future care and treatment or risking the loss of program benefits that you would otherwise be entitled to. Any disputes that arise will be resolved in the state of Wisconsin through the grievance procedure outlined in the initial consent form you were given at intake.

By signing this form: You give consent to your health care service provider for telehealth services and you acknowledge that you have been advised of the risks and been permitted to ask questions about telehealth services.

Client/Guardian Signature:_____Date:_____

Client/Guardian Printed Name:_____

Therapist Signature:_____Date:_____

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