SOUTHERN ILLINOIS INSTITUTE
of Behavioral Health

Distance Counseling/Telehealth Informed Consent

I understand that I have the following rights under this agreement:

1. I have a right to confidentiality with telehealth under the same laws that protect the confidentiality of my medical information for in-person therapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

2. I understand that there are exceptions to my confidentiality including: mandatory reporting of child, elder, and dependent adult abuse; any threats of violence I may make towards a reasonably identifiable person; and also, if I am in such mental or emotional condition to be a danger to myself or others. I understand that in any of these cases my therapist has a right to break confidentiality.

3. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal, and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from telehealth, results cannot be guaranteed or assured.

4. I understand that I have a right to access my medical information and copies of medical records in accordance with applicable Illinois law.

5. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

6. I understand that there are risks unique and specific to telehealth, including, but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failure or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by a better form of psychotherapeutic services I will be referred to a therapist in my geographic area that can provide such services.

7. I understand that other risks include:
    a. Although text messages, voice mail and email are kept confidential, choosing this method may lead to your information not being protected. If you choose to communicate with your therapist in this manner, you must understand the risk.

b. Recording of sessions is never allowable and permission must be granted before authorizing the recording of a session. It is not permitted ever to record any session without the expressed written permission from the participants and this therapist.

8. I understand, acknowledge, and accept any of the inherent risks of my privacy being compromised by being interview via skype, video calling, which is no fault of my therapist, but only those risks dues to privacy issues resulting from the use of electronic communication.

I have read and understand the information provided above. I have the right to discuss any and all of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction

Please note that:

One major issue with Skype is the fact that they have been unwilling to declare that they are HIPAA compliant or sign a BAA (Business Associate Agreement) which is a necessary requirement for HIPAA compliance. This means that Skype does not disclose security breaches or finding from security audits. Therefore, if you use Skype, you do so knowing that you are using a vendor who has declared that they won't provide providers with a "Business Associate Agreement," as mandated by HIPAA.

I_____ hereby consent to participating in psychotherapy via telephone, Skype, or via the internet (hereinafter referred to as "telehealth"). I understand that "telehealth" allows my therapist to diagnose, consult, treat, transfer medical data, and educate using interactive audio, video, or data communication regarding my treatment.

Client Signature *Date*

Provider Signature *Date*