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**TELE INFORMED CONSET FORM**

**Consent, Withholding or Withdrawing of Consent**

I Click or tap here to enter text. (name of individual) hereby consent to engaging in tele counseling with Lori Pahl, LPC as part of my treatment. I understand that “telemedicine” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that tele medicine also involves the communication of my medical/mental information both orally and visually to health care practitioners located in Colorado or outside of Colorado.

I have the right to withhold or withdraw consent at which time services with online counseling will be terminated.

**Privacy:**

The laws that protect the confidentiality of my medical information also apply to tele counseling. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards and ascertainable victim, and where I make my mental emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the tele counseling interaction to researchers or other entities shall not occur without my written consent.

I understand that there are risks and consequences from tele counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that:

1. The transmission of my medial information could be disrupted or distorted by technical failures;
2. The transmission of my medical information could be interrupted by unauthorized persons;
3. And/or the electronic storage of my medical information could be accessed by unauthorized persons.

**Potential Risks and Potential Benefits:**

In addition, I understand that tele counseling based services and care may not be as complete as face to face services. I also understand that if the clinician believes that I would be better served by another form of counseling (i.e. face to face) I will be referred to another clinician who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy and that despite my efforts and the efforts of the counselor, my condition may not improve and in some case may get worse.

I understand that I may benefit from tele counseling but that results cannot be guaranteed or assured.

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

I have read and understand the information provided above. I have discussed it with my clinician provider and all of my questions have been answered to my satisfaction.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE TELE CONSENT FORM DESCRIBED ABOVE.

YOUR SIGNATURE: Click or tap here to enter text.

DATE: Click or tap here to enter text.

THERAPST SIGNATURE: Click or tap here to enter text.

DATE: Click or tap here to enter text.

Copy accepted by client

Copy kept by therapist