Consent for Grief Counseling by Telehealth

I ____, understand as follows:

1. Community Hospice Grief Services has offered to provide me with grief counseling services by means of telehealth. In other words, the counselor will provide counseling by means of video conferencing technology and / or the transmission of data or images.

2. Telehealth counseling services will not be the same as a direct patient/counselor visit due to the fact that I will not be in the same room as my counselor.

3. There are potential risks to the use of this technology for counseling, including interruptions, unauthorized access and technical difficulties.

4. Community Hospice will protect our communication to the same extent as we would protect patient information, and we will use secure technology for the one-to-one telehealth services. But even so, there is still the risk of a breach of security (such as hacking) which could result in others seeing or hearing the communication, or obtaining any data or records transmitted by the technology.

5. I understand others may also be present during the telehealth services other than my counselor in order to operate the telehealth equipment. I further understand that I will be informed of their presence and thus will have the right to request that any such person leave the room for all or part of the session (which may or may not be practical); or terminate the telehealth services at any time.

6. My counselor or I can discontinue these telehealth services if either chooses to do so.

7. There is no charge for this service

____

Signature of Client or Guardian

____

Printed Name of Client or Guardian

____

Printed Name *Child* *Date of Birth*

____

Printed Name *Child* *Date of Birth*

____

Signature of Staff Personnel

Date ___________________________________

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