Compass Counseling Wausau LLC

Client Telebehavioral Health Consent Form

Name: _____ DOB: _____

The transmission of client information by telephone and/ or video conversation has a number of risks that clients should consider prior to the use of a telebehavorial health session.
These include but are not limited to the following risks:

A. The communication may not be HIPAA compliant and the call may not be secure.
B. A recording of the phone or video session could be created, however Compass Counseling will never record any therapy sessions.
C. A phone or video recording can be used as evidence in court.
D. Phone calls may not be secure and therefore it is possible that the confidentiality of such communication may be breached by a third party.

Conditions for the use of phone and/or video sessions: Therapist cannot guarantee, but will use reasonable means to maintain security and confidentiality of information exchanged. The therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Client/ Parent/ Legal Guardian must acknowledge and consent to the following conditions:

A. A phone call or video session is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular phone call or voice message will be listened to and responded to within any particular period of time.
B. Phone calls are to be used for scheduled sessions only. The client/ parent/ legal guardian should call and/ or schedule an appointment to discuss complex and/ or sensitive situations.
C. Transcribed voice messages left on a cellphone can be printed and saved in client's file.
D. Provider will not forward client's/ parent's/ legal guardian's identifiable information given or left without the client's/ parent's/ legal guardian's written consent, except as authorized by law.
E. Provider is not liable for breaches of confidentiality caused by the client or any third party. It is the responsibility of the client/ parent/ legal guardian to ensure session occurs in a private space.
F. **This authorization is only valid for use during the Covid-19 pandemic.**

Revocation: I understand that I have a right to revoke this authorization, in writing at any time by sending written notification to the Privacy Officer at Compass Counseling, Wausau, Attention Privacy officer, 3704 Weston Ave, Weston, WI, 54476. I further understand that a revocation of this authorization is not effect to the extent that action has been taken in reliance on the authorization. Authorization of disclosure to Criminal Justice Agencies will remain in effect and cannot be revoked by me until formal and effective termination or revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment (423CFR Part 2.35).
Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of tele behavioral health sessions between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by phone call at this number.

Phone Number: _____ Okay to leave a message: _____ yes _____ no
I understand that I am entitled to a copy of this release and the information released. Expiration: **This authorization is effective until the temporary COVID- 19 pandemic tele behavior health requirements are reversed.**

_____ _____ _____ _____
Signature of Patient/ Client Date Signature of parent/ guardian Date

_____
Signature of Staff Witness Date