**TURNING POINT COUNSELING TELE-THERAPY INFORMED CONSENT**

I **[name of patient] hereby consent to engaging in tele-therapy with a designated counselor or therapist with Turning Point Counseling as part of my treatment. I understand that "tele-therapy" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications technology. I understand that, with my signed consent, tele-medicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Alaska or outside of Alaska.**

**I understand that I have the following rights with respect to tele-therapy:**

1. **I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.**
2. **The laws that protect the confidentiality of my medical information also apply to tele-therapy. As such, I understand that the information disclosed by me during the course of my therapy 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 an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the tele-therapy interaction to researchers or other entities shall not occur without my written consent.**
3. **I understand that there are risks and consequences from tele-therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my counselor or therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.**
4. **In addition, I understand that tele-therapy-based services and care may not be as complete as face-to-face services and that cultural and/or language differences may affect service delivery.**
5. **I also understand that if my counselor or therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a counselor or therapist who can provide such services in my area.**
6. **I understand that there are potential risks and benefits associated with any form of substance use treatment, or mental health treatment and that despite my efforts and the efforts of my counselor or therapist, my condition may not be improve, and in some cases may even get worse.**
7. **I understand that it is customary for my counselor or therapist to respond within one business day but that is not a guarantee, and that when my provider is not available in the event of an emergency I have been directed to contact 911 or the nearest emergency room.**
8. **I understand that there may be a difference between Alaska and other time zones.**
9. **I understand that I may benefit from tele-therapy, but that results cannot be guaranteed or assured.**
10. **1 understand that I have a right to access my medical information and copies of medical records in accordance with Alaska state law.**

**I have read and understand the information provided above. I have discussed it with my counselor or therapist, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment.**

**Client Signature Date**

**Provider: Counselor/Therapist's Signature Date**

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