Boston Child Study Center

LOS ANGELES

Expert Mental Health Treatment, Training & Research

TELE-HEALTH CONSENT FORM

I ___________________________________am electing to receive remote services, through the aid of web conferencing. I understand that web conferencing is a relatively new and increasingly utilized format with which to deliver evidence-based treatments in clinical psychology. I understand that I am free to decline participation in web conferencing as part of my treatment, and that this will not affect my ability to receive in-clinic care with my therapist, or for my therapist to work with me to identify clinic-based providers in my area.

I understand that, as in any online communication, there is a risk of loss of confidentiality. However, the web conferencing platform being used for my care (Zoom) is HIPAA compliant and uses advanced data encryption technology to minimize the chance of loss of confidentiality. In addition to using a secure web conferencing platform, I understand that my therapist will only conduct sessions from a password-protected network, and that I have been encouraged to do the same.

DOCUMENTATION OF CONSENT

"I have read the above information. I have had the opportunity to discuss it and to ask questions, and I am authorizing the release of my records and clinical material to me via Zoom. I have been informed that I may contact my therapist or one of the Directors of the Boston Child Study Center at any time to answer any questions I may have about the use of web conferencing for the delivery of my care."

________________________________	___/___/___	______________________________
Signature of Patient or Legal Guardian (if patient is under 18)	Date	Name of Patient or Legal Guardian
________________________________	___/___/___	______________________________
Signature of Clinician Obtaining Consent	Date	Name of Clinician Obtaining Consent

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