COMPASS COUNSELING SERVICES

Helping You Towards A Better Direction

I _____ hereby consent to engaging in Mental Telehealth Services Psychotherapy and or Medication Management with **COMPASS COUNSELING SERVICES, LLC.** as part of my treatment. I understand that "telehealth" 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, with my signed consent, telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Florida.

I understand that I have the following rights with respect to Telehealth :
(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 Telehealth . 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 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 Telehealth interaction to researchers or other entities shall not occur without my written consent.
(3) I understand that there are risks and consequences from Telehealth , including, but not limited to, the possibility, despite reasonable efforts on the part of my treatment, 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. In addition, I understand that Telehealth based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of psychiatric services (e.g. face-to-face services) I will be referred to a provider who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatric/psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
(4) I understand that I may benefit from Telehealth , but that results cannot be guaranteed or assured.
(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Florida state law.

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

_____ _____
Name of Patient **Date of Birth**

_____ _____
Name of Natural Parent/Guardian/Other **Date**

_____ _____
Patient/Natural Parent/Guardian/Other Signature **Date**

_____ _____
Witness Signature **Date**

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