Katherine Latter Counseling, PC —*seeing you through the seasons of your life*

CONSENT FOR THERAPEUTIC TREATMENT VIA INTERNET OR TELEPHONE

Internet/Telephone Counseling is the delivery of therapeutic services using interactive video conferencing or telephone device that enables your practitioner to provide treatment at a distant location. I understand that this consultation will not be the same as direct patient/face-to-face visit. Internet/Telephone Counseling will allow me to receive care without the need to visit the office and travel long distance.

I understand that these modes of service include the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of health care data, and I understand that internet and/or telephone counseling also involves the communication of my mental health/health information, both orally and visually, to health care practitioners located in and outside Washington and Oregon. Specifically, these modes of service delivery involve the provision of treatment services via video conferencing or telephonically.

I understand that I have the following rights with respect to internet and/or telephone counseling:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. The laws that protect the confidentiality of my health care information also apply to internet and/or telephone counseling. 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.

3. I also understand that the dissemination of any personally identifiable images or information from the internet and/or tele- phone counseling interaction to researchers or other entities shall not occur without my written consent.

4. I understand that there are risks and consequences from internet and/or telephone counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my health care information could be interrupted by unauthorized persons; and/or the electronic storage of my health care information could be accessed by unauthorized persons.

5. I understand that internet and/or telephone counseling-based services and care may or may not be as complete as face- to-face services. I also understand that if my psychotherapist believes I

would be better served by another form of psycho- therapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist, who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from internet and/or telephone counseling, but that results cannot be guaranteed or assured.

I (We), _____, hereby give permission for information transmission and correspondence between myself and my therapist, Katherine Latter, MA, using telephone and/or video chat. I understand the ramifications of this mode of correspondence and acknowledge the limitations and risks involved which do not insure complete protected exchange of private and/or sensitive information. My signature on this document hereby releases my therapist, Katherine Latter, MA, and Katherine Latter Counseling, PC, from liability due to unforeseen errors in electronic transmission that do not provide total privacy and security of information.

This authorization is valid for the tenure of psychological treatment, unless revoked earlier in writing.

CLIENT PRINTED NAME

SIGNATURE
(All adult clients and, in the case of minors, their legal guardians)

DATE

*Records obtained as authorized by this Consent for Information Release will be maintained in accordance with Federal confidentiality regulations (Title 42 of the Federal Register) which prohibits redisclosure.