



Consent for Telehealth Group

Client Full Name (Including First, Middle, Last):	
Client DOB:	Client ID:

Overview.

All guidelines outlined in the Consent for Telehealth- All programs still apply in addition to group therapy rules. The client must sign both the Consent for Telehealth- All Programs and Consent for Telehealth Group prior to the group therapy session via telehealth.

Reminders for telehealth group services.

- Client and provider must be in a private location
- Group attendees need to mute their microphones if not speaking

Client Consent. Please check each box after the statement has been read.

I consent to participating in group therapy via telehealth. I understand that other group members will also be participating via telehealth.

I commit to upholding the confidentiality of other group members by not allowing anyone outside of the group to view or overhear the group process. I will not share any information about any other group member with anyone else.

I understand that my email address will be able to be viewed by other group members.

DISCLAIMER. This authorization is valid until 9/1/2020

Authorization.

I have been advised of all the benefits, potential risks, and consequences of telehealth. I have had an opportunity to ask questions about this service and all my questions have been answered. I understand the written information provided above.

Client Name: _____

Client Signature: _____ **Date:** _____

I am signing as an authorized representative for the client, I am

Parent of a Minor Court Appointed Guardian/ Conservator (Legal Paperwork Required)

Parent/Guardian Signature: _____ **Date:** _____