



Telehealth Informed Consent

By signing this form, I understand the following:

I understand that the laws that protect privacy and the confidentiality of medical and personal information also apply to telehealth.

George Street Psychology agree to take all available and reasonable precautions to ensure client confidentiality.

I understand that I have the right to withdraw my consent to the use of telehealth services at any time, without affecting my right to future care or treatment.

Client Consent to the use of Telephone and Videoconferencing for consultation:

I have read and understand the information provided above regarding telehealth , have discussed it with the Practice Manager.

I hereby give my informed consent for the use of telephone / videoconference therapy sessions.

Signature of client: _____

Name (printed): _____

Date: _____