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.

The Relationship Room Family Trust and all Providers agree to take all available and reasonable precautions to ensure client confidentiality. However, we are not liable and do not assume responsibility or liability for the acts or omissions of third parties and/or third party service providers.

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

I understand that a variety of alternative methods of counselling may be available to me, and that I may choose one of the options available to me. My Psychologist/Psychotherapist has explained the alternatives to my satisfaction.

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 my Psychologist/Psychotherapist or such administration staff at The Relationship Room, as may be designated, and all of my questions have been answered to my satisfaction.

I hereby give my informed consent for the use of telephone or videoconferencing and I hereby authorize _____ (Name of Psychologist/Psychotherapist) to use telephone or videoconferencing over the course of my therapy.

Signature of Client:

Name of Client:

Date: