Gayle Plessner, Ph.D
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Telemedicine Informed Consent

I _____

(Name of patient, or parent of child under 12 years old)

consent to telemedicine with **Gayle Plessner, Ph.D** as part of my psychotherapy. I understand that "telemedicine" includes the practice of mental health care delivery, diagnosis, consultation, treatment, and education using interactive audio, video, or data communications including Skype and/or telephone.

I understand that I have the following rights with respect to telemedicine:

(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 mental health information also apply to telemedicine. As such, I understand that the disclosed information during the course of therapy is generally confidential. However, there are mandated exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim or one's self; and where mental or emotional states become an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction shall not occur without written consent of the patient or parent of a child under 12 years of age.

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(3) Despite reasonable efforts on the part of my psychotherapist, I understand that disruption or distortion of mental health information by technical failures, and/or interruptions by unauthorized persons may occur. I also understand that telemedicine based services may not be as therapeutically beneficial as in-person psychotherapy sessions; if therapist determines that in-person psychotherapy would be more appropriate than telemedicine and travel is not possible, a referral will be made to a local psychotherapist. Finally, I understand that there are potential risks and benefits associated with psychotherapy, and that sometimes conditions may worsen before they improve.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that my psychotherapist owns all mental health files and that I have a right to access my files within 10 days after submitting a written request in accordance with California law. Should my therapist feel that releasing mental health records would be detrimental in any way, a written summary will be provided instead.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____ _____

Signature of Patient/ Parent Date