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Tele-Mental Health Informed Consent

I, _____ (parent/guardian name), hereby consent to allowing my child, _____ (child's name) to engage in Tele-mental Health with **Melissa Wilson, LMHC** listed below as part of child's psychotherapy. I understand that "Tele-mental Health" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of mental health data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to Tele-mental Health:

(1) I have the right to withhold or withdraw consent at any time without affecting my child's right to future care or treatment nor risking the loss or withdrawal of any program benefits to which my child would otherwise be entitled.
(2) The laws that protect the confidentiality of my child's medical and mental health information also apply to Tele-mental Health. As such, I understand that the information disclosed by my child during the course of therapy 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 self, and/or an ascertainable victim. I also understand that the dissemination of any personally identifiable images or information from the Tele-mental Health interaction to researchers or other entities shall not occur without my written consent.
(3) I understand that there are risks and consequences from Tele-mental Health, including, but not limited to, the possibility, despite reasonable efforts on the part of my child's psychotherapist, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my child's medical or mental health information could be interrupted by unauthorized persons; the electronic storage of my child's medical information could be accessed by unauthorized persons; and/or limited ability to respond to emergencies. In addition, I understand that Tele-mental Health-based services and care may not be as complete as face-to-face services. I also understand that if my child's therapist believes my child would be better served by another form of psychotherapeutic services (e.g. face-to-face services), my child will be referred to a therapist 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 child's efforts and the efforts of my psychotherapist, my child's condition may not be improved, and in some cases may even get worse.
(4) I understand that my child may benefit from Tele-mental Health, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my child's medical and mental health information and copies of medical records in accordance with Massachusetts law, unless this therapist believes allowing parental/guardian access to these records may do unnecessary harm.
(6) I understand that my child's therapist may need to contact my emergency contact and/or appropriate authorities in the event of an emergency. I understand it is my responsibility to also seek appropriate emergency services such as 911 and/or local crisis services (i.e. Riverside Community Care, Norwood) if my child is experiencing a mental health crisis. I agree to inform my child's therapist of the address where my child is located at the time of each session.

I have read and understand the information provided above. I have discussed it with my child, as appropriate, and my child's therapist, and all of my questions have been answered to my satisfaction.

_____ _____

Patient Signature Date
Parent/Guardian Signature (if child is under 18)

MelissaWilson, LMHC
Printed Name of Therapist

Melissa M. Wilson LMHC, #11433
Signature, License, License #