

Yukiko Hartman Psychotherapy
Yukiko Kawabata Hartman, MS, LMHC, LPCC

WA Licensed Mental Health Counselor
LH60182354

CA Licensed Professional Clinical Counselor
LPCC3885

4079 Governor Dr
#3002 San Diego, CA
92122 (206)715-0291
yukiko@yukikopsychotherapy.com

Telehealth Informed Consent

I _____ hereby consent to engage in telehealth (e.g., internet or telephone based therapy) with Ms. Yukiko Hartman, MS, LMHC, LPCC as the main venue for my psychotherapy treatment. I understand that telehealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telehealth also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

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

- (1) **Right to withhold or withdraw consent;** I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- (2) **Confidentiality and exceptions;** The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential.

However, there are both mandatory and permissive exceptions to confidentiality. ([See also Informed Consent for Clinical Services, HIPAA Notice of Privacy Practices forms, for more details of confidentiality and other issues.](#))

- (3) **Risks and consequences of telehealth;** I understand that there are risks and consequences from telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

Appropriateness of Telehealth; In addition, I understand that telehealth based services and care may not yield the same results nor be as complete as face-to-face

service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

- (4) **Benefits of telehealth;** I understand that I may benefit from telehealth, but results cannot be guaranteed or assured. The benefits of telehealth may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.
- (5) **Right to access your medical record;** I understand that I have the right to access my medical information and copies of medical records in accordance with California and Washington law, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated.
- (6) **Physical Location;** I understand that If I am located outside of the States of Washington or California, the counseling services my psychotherapist is allowed to provide to me may be limited or prohibited. If I will be located outside of the States of Washington or California during a telehealth session, I will inform my psychotherapist in advance so we can discuss what services may be available to me.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Client Signature: _____ Date: _____