VIDEOCONFERENCING CONSENT FORM *

Patient Name:_____ Date of Birth:_____

Address:_____

Home Telephone #:_____Cell Telephone #:_____

E-mail:_____

I hereby consent to using live videoconferencing services provided by Audrianna J. Gurr, LPC. I understand that these services may involve the communication of my health information, both orally and visually, to health care practitioners or to you as a patient. Specifically, I understand that videoconferencing services include, but are not limited to, consultation, treatment, and transfer of health data using interactive audio, video, or data communications. I also understand that no data or health information will be recorded, stored, or archived from use of these live videoconferencing services. Written notes will be taken and recorded in my chart as for any other office visit.

I further understand the following with respect to us of Audrianna J. Gurr's videoconferencing services:

1. 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. The laws that protect the confidentiality of my health information may also apply to these services. As such, I understand that the information disclosed by me during any videoconference session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality.

3. There are risks and consequences from use of these services, including, but not limited to, the possibility, despite reasonable efforts on the part of Audrianna J. Gurr, that: the transmission of my health information could be disrupted or distorted by technical failures; and/or the transmission of my health information could be intercepted or accessed by unauthorized persons.

4. I have a right to access my health information and copies of health records in accordance with HIPAA privacy rules and applicable state law.

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

Signature of patient/parent/guardian/conservator:_____ Date:_____

If signature other than patient, indicate relationship:_____ Date:_____

Signature of Health Care Provider :_____Date:_____

*This document is not a HIPAA Privacy Authorization form nor should it be interpreted as such. This consent form applies only to video conferencing services provided by Audrianna J. Gurr, LPC. A separate HIPAA Privacy Authorization Form is used when appropriate. I have a right to access my health information and copies of health records in accordance with HIPAA.