AGREEMENT TO PARTICIPATE IN BINGE GROUP VIA TELEHEALTH

- I agree to participate in group psychotherapy via telehealth which includes live audio and video. I understand I will be able to see and hear the clinician and other participants and they will be able to see and hear me, just as if we were in the same room.
- I agree to participate in the telehealth session in a private space with no other people, distractions or interruptions.
- I understand this group is not individual therapy and is not a replacement for existing therapy or treatment, but an additional support resource. I agree will maintain engagement with my individual therapist (if applicable).
- I will not minimize, judge, or raise conflict around another participant's disclosure.
- I agree to maintain confidentiality for other participants' disclosures.
- I have signed a release for at least one person that the HPA Treatment Team can be in touch with should they have concerns about my medical or psychiatric stability.
- I understand that HPA/LiveWell has implemented safety measures to ensure each telehealth session is secure between the participants and no part of the encounter will be recorded.
- I understand that telehealth sessions must maintain applicable privacy and security requirements, including but not limited to compliance with HIPAA. This means under no circumstance may I record any visual or auditory parts of the telehealth session or discuss the session with anyone other than my provider. ***If I violate this agreement, I will be legally liable for the breach of confidentiality.***
- I recognize that all participants will be advised of the confidentiality requirements and all participants will be required to also sign this form.
- I understand that, although rare, technology problems may delay or interrupt a telehealth session. Technology problems will be corrected as soon as possible. If I get dropped from the session due to an interruption in technology, I will attempt to log back in as soon as possible. If I am unable to connect, I will immediately contact the HPA Admin Team via email to ***frontdesk@albanyhpa.com***.
- If I have any concerns related to my care, I am able and willing to contact either Owner/Director, Dr. Julie Morison or HPA's Administrative Leadership via email at ***frontdesk@albanyhpa.com***.
- I understand that I have the right to withdraw this consent at any time, without affecting my right to future care or treatment.
- By signing below, I have read and understand the information above and have asked any questions I have, and all of my questions have been answered to my satisfaction. I understand the above and hereby give my informed consent to group therapy via telehealth at HPA/LiveWell.

NAME:		CELL PHONE #:	
SIGNATURE:		DATE:	

Authorization for Release of Mental Health Information via Electronic Transmission

Patient Information:

Last Name: _____ First Name: _____ DOB: _____

Phone: _____ Email: _____

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

I AUTHORIZE HPA/LIVEWELL to disclose to (**Person/Provider Information):**

Name: _____ Office: _____

Relationship: Parent☐ Primary Care☐ Med Provider☐ Dietitian☐ Other: _____

Email: _____ Fax: _____ Phone: _____

Release Information:

Release information of my care for the period of: _____ (Start Date) to _____ (End Date)

Purpose for release of information: _____

I request this authorization to be valid and in effect until: _____ (End Date)

Comments:

I request that health information regarding my care and treatment be released as set forth on this form. I understand I have the right to revoke this authorization at any time by contacting HPA/ LiveWell in writing. I understand the risks of sending this information electronically. All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient/Guardian: _____ Date Signed: _____

Printed Name: _____ If not patient, relationship: _____