Hicks Counseling Services
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HICKS COUNSELING HIPAA AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION AND CONSENT/USE OF VIDEO TELEMEDICINE THERAPY SESSIONS

Hicks Counseling is always pleased when patients are willing to utilize video conferencing for therapy sessions. It is generally used as a method for long distance or remote sessions when a patient requests such a service from Hicks Counseling.

Hicks Counseling respects the privacy of our patients. Ensuring that medical information is kept confidential is among our highest priorities. Hicks Counseling seeks your permission to use your medical information and your consent to allow for video conference sessions.

To ensure that Hicks Counseling is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form. Hicks Counseling will keep a copy of your written permission on file.

I do give my permission for Hicks Counseling to use my name and share details of my treatment and experience as a patient electronically through the following means;

____ I do give Hicks Counseling permission to call me for my therapy sessions through Google Hangouts utilizing Google Voice

____ I specifically authorize the release and discussion of information pertaining to my mental health diagnosis or treatment through video conferencing

____ I specifically authorize Hicks Counseling to video call me at ________________________ during my scheduled video sessions

- I am not required to sign this authorization.
- Hicks Counseling does not condition treatment, diagnosis, payment, or benefit eligibility on the signing of this form.
- Video conferencing has been made upon my request and I can revoke it at any time.
- Video conferencing is for my convenience and I understand that the above video services are currently not HIPAA compliant.
- I can request a copy of this authorization be mailed to me.
- If I decide to sign this form, I have the right to request video cease at any time.
- I am aware that my protected health information will exist forever in possibly a recorded, printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used.
- I must send written notice to Hicks Counseling in order to revoke my permission to use video conferencing.
- I understand that Hicks Counseling, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Hicks

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HIPPA Notice to use Video Conferencing

Counseling control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

Patient Name: ______________________________ _______ ______________________________

(first) (m. initial) (last)

Signature: ____

Date: ____

Address: ____

(street address) (city) (state) (zip code)

Phone: ____ H M

(area code) (home or mobile phone number)

For personal representatives, the authorization to use video conferencing is not permitted at this time.