Kathleen Doherty Robinson PsyD LLC
Licensed Psychologist #2284
1720 S. Bellaire, Suite #203
Denver, CO 80222
303-782-0433

Telehealth Informed Consent

Telehealth allows Kathleen D. Robinson, Psy.D. to conduct psychotherapy sessions using interactive audio, video or data communication. Telehealth sessions will be delivered from a private office space and records will be kept in a locked cabinet to ensure confidentiality

There are risks unique and specific to Telehealth, including but not limited to, the possibility that sessions could be disrupted or distorted by technical failures or could be interrupted or accessed by unauthorized persons. It is the client's responsibility to find a private place to have the session, use a secure internet connection and sustain from using any substances (alcohol, marijuana, etc.) prior to or during sessions.

Information shared during Telehealth is legally confidential and cannot be disclosed without client consent or the consent of the client's parent/guardian. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report child and elder abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The exceptions to confidentiality include but are not limited to: reporting of suspected child or elder abuse or neglect to law enforcement; reporting any threat of imminent physical harm by a client to law enforcement and to the individual(s) threatened; conducting a mental health evaluation of a client who is of imminent danger to self or others or who is gravely disabled, as a result of a mental disorder; disclosing treatment information in response to a court order; disclosing treatment information to your insurance company and associated managed care organization for purposes of reimbursement; and reporting any suspected threat to national security. Please note, if you are a minor (age 17 or younger) and engage in behaviors associated with an eating disorder and/or self-injurious behaviors, your parents/guardians will be notified.

By signing this form, I acknowledge that I have read and understand the preceding information. I understand that I can withdraw my consent to Telehealth at any time by providing written notification. By signing this form, I agree to the terms of this agreement. I also agree that I will not record any portion of the telehealth sessions.

Print Client's Name	Print Name of Parent/Guardian/Responsible Party
Signature of Client	Signature of Parent/Guardian
Kathleen D. Robinson, Psy.D.	Date