Glenview
Counseling Group

Authorization &
Statement of Understanding:
Audio/Visual Sessions

Client Information

Name _____ Date of Birth_____

Home address _____ Zip_____

Phone: (Work)_____ (Home)_____ (Cell)_____

I hereby authorize Glenview Counseling Group and its associates to use any forms of telecommunication as a means for psychotherapy. I understand that some forms of telecommunication do not meet the standards set forth by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and that there is a greater risk to privacy than with traditional psychotherapy. I further attest that since I have chosen this form of communication I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy which incorporates telecommunication. I understand that at no time will this communication be recorded in any way by my psychotherapist.

I understand that I may revoke this authorization at any time by giving written notice, except to the extent that Glenview Counseling Group has already taken action in reliance on it. I may specify the date, event, or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

_____ _____

Client's signature (age 12 and older) Date

_____ _____

Parent/guardian of minor OR of legally disabled recipient Date

_____ _____

Witness signature Date