**OUSD Counseling Intern Program Telehealth Consent**

1. I understand that “teletherapy” includes secure video conferencing, emails and telephone conversations
2. Unless I explicitly provide agreement otherwise, teletherapy exchanges are strictly confidential. Any information my child or I choose to share with my counseling intern will be held in the strictest confidence. My private information will not be released unless the counselor has reasonable suspicion that someone is about to physically harm someone else, harm themselves, or if there is abuse of children, the elderly, or the disabled.
3. I understand that teletherapy services are furnished in the state of California, USA and the services provided are governed by the laws of that state.
4. I understand that I have the right to withdraw or withhold consent from teletherapy services at any time. I also have the right to terminate counseling at any time.
5. While teletherapy will be conducted primarily through secure and private videoconferencing, I understand that there are always some risks with teletherapy services including, but not limited to, the possibility that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your information could be intercepted by unauthorized persons, and/or the electronic storage of your medical information could be accessed by unauthorized persons.
6. I will work with my counselor to identify an alternative communication method (most often phone) in the event that the videoconferencing tool fails.
7. I understand that my child or myself (adolescent) may benefit from teletherapy but that results cannot be guaranteed or assured.
8. I understand and accept that teletherapy does not provide emergency services. If my child or I are experiencing an emergency, I understand that the protocol would be {to call 911 or proceed to the nearest hospital emergency room for help. If my child or I am having suicidal thoughts or making plans to harm myself, I may also call the National Suicide Prevention Lifeline at 1- 800-273-TALK (8255) for free 24 hour hotline support.}
9. I will be responsible for the following: (1) providing the computer and/or necessary telecommunications equipment and internet access (2) arranging a location is confidential for my child’s or my (adolescent) teletherapy sessions.
10. I agree not to record teletherapy sessions.
11. I have the right to access my child’s medical information and copies of my medical records in accordance with HIPAA privacy rules and applicable state law.
12. I understand that services delivered by the counseling intern are required by law to take place within California exclusively
13. I understand that if the counseling intern is concerned about my child or me or we lose contact, or if my child/I fail to show for a scheduled videoconference, the counseling intern will contact me by phone to check on our well-being. In addition, if my child or I am showing signs of being in real trouble, the counseling intern program requires that we have permission to contact someone to ensure safety. The program require three levels of contacts:
14. A close personal contact such as another caregiver or family member in the household

Personal Contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The contact of my doctor or my child’s pediatrician

Professional contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The office or Agency that does crisis well-being checks in your community (typically a 24-hour crisis service or the police department).

Crisis response: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of legal guardian/consenting minor is required below:

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Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_