WILLIAM PATERSON UNIVERSITY
COUNSELING, HEALTH & WELLNESS CENTER

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEHEALTH (COUNSELING) CONSULTATION

Purpose: Telehealth involves the use of electronic communications to enable **Counseling, Health and Wellness Center (CHWC)** mental health professionals and support staff to deliver counseling services using interactive video and audio communications.

Nature of Telehealth Consultation: This scope of service includes the practice of psychological health care delivery in regards, but not limited to, consultation, treatment, referral to resources, and psychoeducation.

I understand that I have the following rights with respect to telehealth:

1. **Confidentiality:** In accordance with applicable state and federal laws that protect the confidentiality of my personal information, the same applies to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. I understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

   Limitations to Confidentiality: There are both mandatory and permissive exceptions to confidentiality. These exceptions include:
   a) Where the counselor must disclose to authorities language or behavior consistent with wanting to hurt myself through suicide, with identifiable means, intent and plan, and/or,
   b) Through expressed verbal, written or behavioral threats of violence toward an ascertainable victim,
   c) Where the counselor must disclose to authorities my personal health information when abuse of a child or elder is suspected, on-going and/or intended child and/or elder abuse.

2. **Risk and Consequences:** I understand that CHWC mental health counselors and staff will make every effort to protect my personal information. However, I understand that there are potential risks and consequences from telehealth. Some of these risk factors include, but are not limited to:
   a) Transmission of my personal information while in session could be disrupted or distorted by technical failures,
   b) The transmission of my personal information could be intercepted by unauthorized persons,
   c) The electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.

   Please note that CHWC takes great care to protect your personal information, and utilizes secure audio/video transmission software to deliver telehealth.

3. **Rights:** I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment

4. **Limitation of Telehealth Services:** I understand that if my counselor believes another form of intervention (e.g., face-to-face services, Intensive Outpatient Services) would better serve my mental health needs I will be referred to outpatient mental health professionals/facilities that could deliver the appropriate level of care.

5. **Interdepartmental Sharing of Information:** I understand that my healthcare information may be shared with other staff within Counseling Health and Wellness Center for scheduling and/or medical consultations.

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Consent to the Use of Telehealth:

I have read and understand the information provided above regarding telehealth, especially the risks and benefits related to the use of telehealth services. I have had an opportunity to ask questions about this information and my questions have been answered. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Print Student Name _____ **855**_____

Student Signature_____ **Date** _____