EMORY UNIVERSITY | Student Health Services
Campus Life

TELE-HEALTH INFORMED CONSENT

I_____(**name of student/patient**) hereby consent to engaging in telehealth clinical services with a medical or mental health provider at Student Health Services (SHS). Telehealth is a broad term that refers to health services and information provided electronically or with the use of technology. I understand telehealth may include medical or mental health education, diagnosis, consultation, treatment including prescription medications and ordered labs/medical imaging, and referrals to resources. Telehealth services with SHS will occur primarily through online video conferencing or telephone and may involve secure messages, text messages, and email exchanges.

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

1. I have the right to withhold or withdraw consent at any time. If consent is withheld or withdrawn, students may meet with a provider onsite at the SHS office. In some instances where meeting at the SHS physical location is not possible, your provider may need to refer you to another provider who can appropriately provide this service.

2. The use of telehealth services is subject to the discretion of a SHS clinical provider, and is based upon the assessment of a student's clinical needs.

3. For a student to receive telehealth services, they must be physically located in a state where the provider is licensed (i.e., Georgia). Telehealth service cannot be provided in international jurisdictions.

4. Prescriptions for controlled substance medications may be limited by Federal and Georgia laws.

5. Telehealth appointments occur at the times agreed upon between you and your provider. If you miss your scheduled appointment, you must contact your provider or the SHS office (404-727-6145) in order to reschedule.

6. Telehealth services cannot be provided to students who are minors, unless this consent form is also signed by a parent or guardian.

7. The laws that protect the confidentiality of your personal information and clinical treatment record also apply to telehealth services. As such, I understand that the information disclosed by me during the course of telehealth sessions is generally confidential. However, there are exceptions to confidentiality, including, but not limited:

    - The student is in imminent danger of harm to self or others and it is necessary to ensure the student's and/or other's safety.
    - The provider has reason to suspect the presence of abuse or neglect of a child, an elderly person, or dependent adult; and must make a mandatory report to DFCS.
    - A SHS staff member is presented with a valid court order
    - The student is a minor and information is requested by their parent or guardian.

8. I understand that my sessions via telehealth will not be recorded by the SHS provider. I understand that the dissemination of any personally identifiable images or information from the telehealth interactions to other entities shall not occur without my written consent.

9. I understand that there are risks and consequences from telehealth. These include, but are not limited to, the possibility, despite reasonable efforts on the part of the clinical provider, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons.

    Another risk is that students may experience loss of confidentiality due to factors from the surrounding environment in which they chose to participate in telehealth services. Students are encouraged to ensure that no one else is the room, not to participate in conversations while on speaker phone, or to participate in a public space.

    In addition, I understand that telehealth sessions may not be as complete as face-to-face services. I also understand that if my SHS provider believes I would be better served by another form of intervention (e.g. face-to-face services) I will be referred to a clinical professional who can provide such services in my area.

    Finally, I understand that I may benefit from telehealth clinical services, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of clinical treatment, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.

10. I understand that there may be an incurred cost from participating in telehealth services (i.e. cost of phone call, use of minutes from a phone plan) and that I am responsible for covering these costs.

11. I understand that I have a right to access my personal information and copies of case

records in accordance with Federal and Georgia law. I have read and understand the information provided above. I understand that if I have any questions I am free to discuss them with my SHS provider.

12. By signing this document I agree that certain situations including emergencies and crises are inappropriate for telehealth counseling services.

    - If I am in crisis or in an emergency I should immediately call 9-1-1, the National Suicide Hotline at 1-800-784-2433, or the Georgia Crisis Line at 1-800-715-4225; or seek help from a hospital or crisis oriented health care facility in my immediate area. I understand that emergency situations include if I have thoughts about hurting or killing either another person or myself, if I have hallucinations, if I am in a life threatening or emergency situation of any kind, having uncontrollable emotional reactions, or if I am dysfunctional due to abusing alcohol or drugs.

    - I acknowledge I have been told that if I feel suicidal, I am to call 9-1-1 or other local suicide hotlines.

We hope your experience with our services is a positive one. If at any time you have any questions or concerns about your experience, please feel free to contact SHS at 404-727-7551.

Your signature below indicates that you have read the information in this document and agree to abide by its terms while you are receiving services from Student Health Services (SHS).

Signature:_____ **Print Name**: _____

Student ID:_____ **Phone #**: _____

Date: _____

For students who are under age eighteen:

Signature of Parent/Legal Guardian: _____

Print Name:_____Date:_____