# Informed Consent for Telemental Health Services

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|---|---|---|
| Client Name: | Date of Birth: | Today's Date: |
| Parent/Guardian Name (if applicable): | | |
| Address: | City: | State: |
| Email Address: | Home Phone: | Cell Phone: |

Due to the COVID-19 pandemic and the state of emergency declared in the state of Mississippi, in-person visits at the University of Mississippi Clinic for Outreach and Personal Enrichment (COPE) have been disrupted. In order to ensure continuity of care, consistent with the public health guidance issued by the Mississippi Department of Health, the COPE Clinic is offering its services via telehealth systems.

Telehealth is the delivery of healthcare through the use of interactive audio and video communication with a provider who is at a different physical location. The telemental health consultation will be similar to a routine office visit, except interactive video technology will allow communication with the provider at a distance. The telehealth systems used will incorporate network and software security protocols to protect the confidentiality and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

1. Consent to Telemental Health Services. I consent to telemental health services performed by my mental health providers and all other associated mental health providers at the University of Mississippi COPE Clinic (the "Provider(s)"). This includes the provision of education, goal setting, accountability, additional mental health resources, problem solving, skills training, and help with decision making. Telehealth psychotherapy may include psychological health care delivery, diagnosis, consultation, and psychotherapeutic treatment that may be deemed necessary in my Provider's professional judgment. I also understand that I have the option to refuse the delivery of mental health services by telehealth at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled. I understand that:

    a. At the beginning of each telemental health session, I must show a photo ID to the Provider to verify my identity, and I must provide the name and number of my local designated emergency contact.
    b. I understand that the Provider may contact my designated emergency contact before the session begins to verify that she or he is available.
    c. I understand that there are certain limitations to telemental health session, and that my Provider will determine whether or not the condition being diagnosed and/or treated is appropriate for a telehealth encounter.
    d. I understand that if my Provider determines that a telehealth encounter is not appropriate, I will be provided a resource guide for local mental health providers.
    e. I will be informed of any other people who are present at either end of the telemental health encounter, and have the right to exclude anyone from either location.
    f. All confidentiality protections required by law or regulation will apply to my care.
    g. I will have access to all medical information resulting from the telemental health service as provided by law, and that my express permission is required before my medical information may be shared with a third-party, unless otherwise allowed by law.
    h. I have the right to refuse or stop participation in telemental health services at any time, and I may request alternate services such as a resource guide for local mental health providers or crisis hotline numbers. However, I understand that equivalent in-person services might not be available at the

Please Initial after reading this page: _____

same location or time as telemental health services, and I may have to travel to see a mental health care provider in-person.

i. If an emergency occurs during a telemental health encounter, I should call 911 and stay on the video connection (if applicable) until help arrives.

2. Telemental Health Session Protection. I understand that the University of Mississippi COPE Clinic has taken the appropriate security measures to ensure that each telemental health session is secure by providing the telehealth sessions through a HIPAA compliant platform; encrypting my healthcare data; and, placing safeguards on the systems used to access my data.

3. Telehealth Session Risks. I understand that there are potential risks and benefits associated with any form of counseling, including counseling provided through telemental health services, and that despite my efforts and the efforts of my Provider my condition may not improve, and in some cases may get worse.

   I understand that there are potential risks associated with the use of telehealth systems. I understand that these risks include, but are not limited to the following:

   a. Interruption of the audio/visual link;
   b. Disconnection of the audio/visual link;
   c. A picture that is not clear enough to meet the needs of the Providers during the session;
   d. Electronic tampering; and,
   e. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

   I understand that if any of these risks occur, the telehealth session may need to be stopped.

4. Location for Telehealth Sessions. I understand that different states have different regulations for the use of telehealth. I understand that in order for the Providers to participate in a telehealth session with me, I must be physically present within the state border of Mississippi. I understand that for each telehealth session I will be asked to confirm that I am physically present within the state of Mississippi for that session. In order to ensure the confidentiality of my telehealth counseling session, I agree to participate in the session from a safe, private, and quiet environment and not record the session. If I am unable to meet this requirement, it is my responsibility to discuss these issues with my clinician, who may decide on the most appropriate course of action, which may include, but is not limited to my Provider providing me with a resource guide for a local mental health provider.

5. Confidentiality. I acknowledge and understand that the COPE Clinic and my Provider have certain duties and obligations that may require the disclosure of my confidential information under certain situations, including, but not limited to:

   a. A duty to warn about serious harm to myself.
   b. A duty to warn about serious harm to others.
   c. An obligation to report to the appropriate state agency current child abuse or neglect, elderly abuse, or otherwise disabled individual abuse.
   d. An obligation to respond to a valid subpoena or court order seeking the disclosure of my records.

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I also understand that my Provider may disclose my confidential information to any other person or entity of my choice upon receipt of a valid and executed release of information from me.

6. Situations of Crisis and Emergencies. I understand that certain situations including emergencies and crises are inappropriate for audio/video/computer-based counseling services. I acknowledge and understand that if I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. I understand that emergency situations include having thoughts about hurting or killing either another person or myself, hallucinating, if I am in a life threatening or emergency situation of any kind, have 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 contact one of the following resources:
   a. Emergency Services (911)
   b. National Suicide Prevention Lifeline (1-800-273-8255)
   c. Crisis Text Line (Text: HOME to 741-741)
   d. University Police Department (662-915-4911) if local

## Consent to the Use of Telemental Health Services

I have read and understand the information provided above regarding telemental health services. I understand that I will have an opportunity to discuss the terms of this consent with my provider at the start of my telehealth session. I acknowledge and agree to present all of my questions to my provider, if any, and to not proceed with my telehealth session until all of my questions have been answered to my satisfaction. I understand that by continuing my participation in the telehealth session I am asserting my understanding and agreement to the information provided in this consent form.

I hereby give my informed consent to participate in the use of telemental health services for treatment under the terms described herein. I give my Provider permission to speak with my emergency contact if necessary.

By signing below, I agree to the statements above as authorized.

Signature of
Client/Legal Representative: _____ Date: _____
*(Please type your full name if you are electronically signing)*

Relationship to Client: _____