THE UNIVERSITY of MISSISSIPPI

Mental Heath Counselors on Campus at
Counselor Education Clinic for Outreach and Personal Enrichment

Client Information and Consent to Treatment Form

Mental Health Counselors on Campus (MHCOC) is a telemental health program that was established to provide counseling services to Mississippi's K-12 students. MHCOC is housed within the Counselor Education Clinic for Outreach and Personal Enrichment (COPE), which was established to provide counseling services for children and families and individuals. Your counselor may be a licensed professional counselor or a graduate student counselor who is supervised by a licensed professional counselor.

All matters conducted at MHCOC/COPE are confidential and governed by the laws of HIPAA and the state of Mississippi. ***There are exceptions to confidentiality. If there is evidence of imminent danger or harm to yourself, your child, and/or others, a counselor is legally required to report this information to the appropriate authorities to insure the safety of everyone involved. Any case of suspected child abuse will be immediately reported to the department of human services, (DHS). We also must comply with any subpoenas received by a court of law.*** Any disclosures other than the ones mentioned in this form will require consent for release of information form signed by the parent or legal guardian.

Children specific information

Play therapy is a method used for counseling children ages 4-12 years old. General counseling is used for children ages 13-18 years old. Play therapy allows the client to express problems in a developmentally appropriate manner, and research supports the effectiveness of play therapy with children experiencing a wide variety of problems. Play therapy modifications may be necessary due to the delivery of services via telemental health. Play therapy sessions are approximately 45 minutes long and are dedicated to the child.

Acknowledgement of Counseling

By signing below, you acknowledge that you are aware that you or your child,

_____ will be receiving counseling services via telemental health through the Mental Health Counselors on Campus program at the Counselor Education Clinic for Outreach and Personal Enrichment. I am aware that I may contact the therapist, at (662) 915-7197 or by email at cope@olemiss.edu should I have any questions.

All sessions will begin with an initial interview. The purpose of this interview is to determine your needs and to appoint a counselor.

Client Information

Name:_____

Gender Identity: ☐ M ☐ F ☐ Other

Address:_____

City/State/Zip_____

Phone:_____

Email:_____

SSN:_____

DOB:_____

Employer:_____

Child/Adolescent Information

Child's Name:_____

Gender Idenitity: ☐ M ☐ F ☐ Other_____

City/State/Zip:_____

Phone:_____

Email:_____

SSN:_____

DOB:_____

By signing below I certify that the information provided by me in this document is true and correct. I agree to all the terms within this document and I have received a copy of the Notice of Privacy Practices.

HIPAA INFORMATION:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign below to acknowledge receipt of this Notice. You may refuse to sign this acknowledgement if you wish, however refusal to sign this Notice will result in termination of any potential work with this program/clinic.

_____
(Please type your full name if you are signing electronically)

_____
Printed Name/Relationship to Client

_____
Date

_____
Intake Counselor

_____
Assigned Counselor and Date

Alexandria Kerwin, Ph.D., LPC-S, NCC
Associate Professor
Clinical Director

2301 S. Lamar Blvd.
University, MS 38677-1848
Phone: 662-915-7197
Fax: 662-915-1363
Email: cope@olemiss.edu

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU AND/OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective June 1, 2021

1. PURPOSE: Mental Health Counselors on Campus (MHCOC) at the Counselor Education Clinic for Outreach and Personal Enrichment, (COPE), and its professional staff, employees and trainees follow the privacy practices described in this Notice. MHCOC/COPE keeps your mental health information in records that will be maintained and protected in a confidential manner. Please note that in order to provide you with the best possible care and treatment, all professional staff involved in your treatment and employees involved in the health care operations of the agency may have access to your records.

2. WHAT ARE TREATMENT AND HEALTH CARE OPERATIONS? Your treatment includes sharing information among mental health care providers who are involved in your treatment. For example, if you are seeing both a physician (psychiatrist) and a psychotherapist, they may share information in the process of coordinating your care. Treatment records may be reviewed as part of an on-going process directed toward assuring the quality of Agency operations.

3. HOW WILL MHCOC/COPE USE MY INFORMATION? The record that is maintained by clinicians at MHCOC/COPE will be designated as your mental health record and may include the following: information pertaining to medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. . Psychotherapy notes are not a part of your designated mental health record and as such will not be released to other entities without special permission and for therapeutic reasons may not be available for release to clients. These notes contain more sensitive and personal information than the progress notes and could include the following: notes recorded in any medium by a mental health provider documenting or analyzing the contents of a conversation during a private, group, joint or family counseling session, and that are separated from the rest of the individual's medical record. Tape recordings or other types of electronic recording are not part of your protected mental health record.

Your personal mental health record will be retained by MHCOC/COPE for approximately six years after your last clinical contact with the agency. After that time has elapsed, the record will be destroyed in a way that protects your privacy. Until the records are destroyed, information revealed by you will be kept confidential except under the following conditions:

A. We reserve the right to seek supervision and consultation from professional colleagues within our agency, which will aid us in our work with you. These colleagues, also, will treat your information as confidential. Information discussed in consultation may include protected mental health information.

B. Information obtained by MHCOC/COPE staff involved in your health care will be recorded in your clinical record and used to determine the course of treatment that should work best for you. Information gathered may be used for creating an assessment, developing a treatment plan, recording your progress in treatment, and assisting in writing your after-care plan.

C. If we believe you pose a life-threatening risk to yourself or others, we may need to notify responsible individuals for your protection or the protection of others.

D. Cases of suspected abuse or neglect of children or adults not otherwise able to protect themselves may be reported in compliance with state law.

E. If records are court ordered to be released.

F. If otherwise required by state or federal law.
Due to the confidential nature of our services, client records are handled with great sensitivity. All staff members are trained in understanding and respecting client confidentiality. Staff handle records only when necessary. Client files are securely stored.
MHCOC/COPE compiles statistical data (e.g. demographic information, presenting concerns) to measure effective treatment and improve services. Names or other information that would identify specific clients is never a part of that statistical data.

4. YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES. Except as described previously, we will not use or disclose information from your record unless you authorize (permit) in writing for MHCOC/COPE to do so. You may revoke your permission, which will be effective only after the date of your written revocation.

5. YOU HAVE RIGHTS REGARDING YOUR HEALTH INFORMATION. You have the following rights regarding your health information, provided that you make a written request to invoke the right on the form provided by MHCOC/COPE.

➢ Right to request restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

➢ Right to confidential communications. You may request communications in a certain way or at a certain location.

➢ Right to inspect and copy. You have the right to inspect and copy your mental health information regarding decisions about your care; however, we reserve the right to withhold release of psychotherapy notes in some circumstances. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request for a copy of your records may be denied; you may request review of the denial by another licensed mental health professional chosen by MHCOC/COPE. MHCOC/COPE will comply with the outcome of the review.

➢

➢ Right to request clarification of record. If you believe that the information we have about you is incorrect or incomplete you may ask to add clarifying information. You may ask for a form for that purpose and the form will require certain specific information. MHCOC/COPE is not required to accept the information that you propose.

➢ Right to a copy this notice. You may request a copy of this notice at any time, even if you have been provided with a copy previously.

6. REQUIREMENTS REGARDING THIS NOTICE: MHCOC/COPE may change its policies or procedures in regards to privacy practices. If and when changes occur, the changes will be effective for mental health information we have about you as well as any information we receive in the future. Any time you attend an MHCOC/COPE an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time.

7. COMPLAINTS: If you believe your privacy have been violated, you may file a complaint with the American Counseling Association Ethics Board. You will not be penalized or retaliated against in any way for making a complaint.

If you have any concerns about your privacy, wish to request any restrictions on uses or disclosures of your mental health information, or wish to obtain any of the forms mentioned previously in this document, speak with your counselor or the clinic director.

MHCOC/COPE Counselor Education Clinic
2301 S. Lamar Blvd.
South Oxford Center
Office: (662) 915-7197
Fax; (662) 915-1363

Informed Consent for Telemental Health Services

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.

Please Initial after reading this page: _____

Informed Consent for Telemental Health Services

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: _____

THE UNIVERSITY of MISSISSIPPI

COUNSELOR EDUCATION CLINIC FOR OUTREACH AND PERSONAL ENRICHMENT

Request for an Individual's Health Information / Treatment Records and Authorization to Release

Last: **First:** **Middle:**

Date of Birth:

Address: **Phone: ( )**

X I hereby request access to the protected health information in my health record, covering the period from (date) _____ to (date) _____

- ☐ Session Attendance Record
- ☐ Treatment Issues
- ☐ Discharge Summary
- ☑ Other: Emergency Contact
- ☐ Recommendations
- ☐ Treatment Plans
- ☐ Diagnosis
- ☐ Mail copies of my records to the individual noted below :

Communication between	Emergency Contact's Information
Name: Counselor Education Clinic (Cope)	Name of emergency contact:
Address: 2301 S. Lamar Blvd. University, MS 38677	Address:
Phone: 662-915-7197	Phone:
Fax: 662-915-1363	Fax:

Purpose of Request: ☐ patient's request, ☐ continuity of care, ☐ referral, ☑ other: Telehealth

I understand:

- I may revoke this authorization at any time by providing my written revocation. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.
- For non-students, information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.**
- The information authorized for release also may include protected health information related to mental health.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2) The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released

_____ _____ _____

(Client type your full name if you are signing electronically) Relationship to Client Date

_____ _____ _____

Signature of Witness Print Name Date

THE UNIVERSITY of MISSISSIPPI

MENTAL HEALTH COUNSELORS ON CAMPUS AT

COUNSELOR EDUCATION CLINIC FOR OUTREACH AND PERSONAL ENRICHMENT

Informed Consent and Disclosure Statement

Welcome to the Mental Health Counselors on Campus program at Counselor Education Clinic for Outreach and Personal Enrichment. We are pleased to have you as a client at MHCOC/COPE. Our goal is to provide you with the best services possible. In order to do this, we seek to work with you as a team to ensure your successful treatment. As we are a training clinic, regular attendance to your counseling sessions not only provides you with consistent treatment, but also offers our clinicians the opportunities to sharpen their skills. Therefore, we ask the following:

- Please show up for your appointments on time; if you are going to be late, please call the clinic to let your clinician know.
- If you need to cancel or reschedule your appointment, please contact us at least 24 hours in advance.
- If you miss two (2) consecutive sessions, you will be notified via mail and asked to respond within two weeks of the date listed. If you do not respond within the allotted time, you will no longer be able to keep your regular appointment time and future sessions will be terminated. In the unfortunate event that you contact us after this allotted time seeking services, you may be placed on a waitlist or referred to another agency.
- If at any time you are concerned with your quality of treatment, please contact Dr. Alex Kerwin, at 662-915-7197 or cope@olemiss.edu.

Your counselor is an advanced graduate student in either a Master's Degree Program or a Doctoral Degree Program in the Counselor Education Department at The University of Mississippi. Your counselor works under the supervision of a counseling faculty member who is a Licensed Professional Counselor in the State of Mississippi. Due to COPE being a training clinic, you may be referred to another agency in the event that your needs may be best met by a different clinician. This will be at the discretion of the counselor's supervisor and Clinic Director.
Counseling sessions in the Clinic are video recorded and may be observed. This is done for the purpose of providing your counselor with feedback to enhance the services you receive. All tape recordings are destroyed at the end of the semester. Feel free to ask your counselor any questions that you may have about these procedures.

SERVICES NOT PROVIDED BY MHCOC/COPE:

- Emergency Services
- Formal Assessments or Psychological Testing
- Third Party Payment Reimbursements
- Custody Agreement Mediation
- Forensic Investigating
- Medication Management

THE COUNSELING RELATIONSHIP
Counseling involves the sharing of personal problems, concerns, and stories with a professional who is skilled at helping the client or clients come to a resolution or solution about the particular situation. Counseling is a relatively short-term, interpersonal, theory based professional activity guided by ethical and legal standards that focuses on helping persons resolve developmental issues, situational problems, and more complex personal diagnoses.

The general goals for the client are that he or she can identify the issues, develop a plan of action, and then implement that plan. This is a very personal process. It is educational and developmental by nature.

CHLDREN SPECIFIC INFORMATION
Play therapy is a method used for counseling children ages 4-12 years old. General counseling is used for children ages 13-18 years old. Play therapy allows the client to express problems in a developmentally appropriate manner, and research supports the effectiveness of play therapy with children experiencing a

wide variety of problems. Play therapy modifications may be necessary due to the delivery of services via telemental health. Play therapy sessions are approximately 40-45 minutes long and are dedicated to the child.

Parent consultations should occur regularly through the play therapy process. However, discussions between the parent/guardian and the child's counselor will be reserved for a separate time from the play therapy sessions. This is to maintain the quality of the relationship between the child and the counselor. Parent consultations will occur via secure videoconferencing. However, exceptions will be made to occur over the phone in the event of scheduling conflicts. If you have any concerns related to your child, please contact your counselor by emailing cope@olemiss.edu with "ATTN. Counselor Name" in the subject title and s/he will contact you.

CODE OF CONDUCT

The Department of Counselor Education requires our counselors to adhere to a specific Code of Ethical Conduct that is determined by the American Counseling Association. Should you have a questions or concern about your counselor's conduct, please feel free to contact the Counseling Clinic Director, Dr. Alex Kerwin, Ph.D., LPC-S, NCC at 662-915-7197.

The State of Mississippi requires counselors to adhere to a specific Code of Conduct that is determined by the Board of Counseling. Should you wish to file a complaint, you may do so through:

Mississippi State Board of Examiners
for Licensed Professional Counselors
239 North Lamar Street
Jackson, MS 39201
https://www.lpc.ms.gov/secure/complaintmain.asp
Office: 601-359-1010

CONFIDENTIALITY

We place a high value on the confidentiality of information that you share with your counselor. Your right to privacy is governed by legal and ethical guidelines. Generally, the information you share with your counselor is not shared with anyone else without your expressed written permission. Confidentiality may be broken when the client is a threat to themselves (suicide) or another (assault/murder) or when your counselor is made aware of child or elder abuse. In all cases the counselor will discuss his or her concerns with the supervisor or the Counseling Clinic Director. Your counselor can discuss these instances in detail at your request or you may contact the Counseling Clinic Director.

At times a court of law may order disclosure of confidential information. In such a case your counselor would either request your permission or request that the court not require the information as it would damage the counselor/client relationship and impede your healing. If required, only minimal information is disclosed.

Other instances where your counselor would need to share information with others will be discussed with you in session (e.g., insurance forms, school conferences, etc.). Do not hesitate to ask your counselor questions about confidentiality at any time throughout the counseling process.

LENGTH, FREQUENCY, & RISKS

Counselors may work at MHCOC/COPE for one semester (approximately 15 weeks). You and your counselor will decide how long your counseling will last and how often you will attend sessions. For most clients, sessions last about fifty minutes and are scheduled once a week. However, depending upon the nature of your concerns, you may be seen less frequently. Your counselor will work with you to arrange for your continuation with another counselor at MHCOC/COPE or for an outside referral if you do not feel that your concerns are resolved at the end of the semester.

As a result of counseling, you may realize that there are additional issues that did not surface prior to the onset of counseling. This is an inherent risk in any counseling relationship. Also, couples, marriage, and family counseling may involve certain risks. As one person changes in any relationship, stresses and

strains are created. This is a part of the counseling process and is dealt with within the counseling relationship.

CLIENT RESPONSIBILITIES
In order for your work with MHCOC/COPE to be productive, it is important that you attend counseling sessions and make an effort to work on the issues being addressed. If for some reason you cannot attend a scheduled session, please call in advance and leave a message with the front desk. You may be able to reschedule at that time; otherwise, your counselor will contact you to reschedule.

CONTACTING YOUR COUNSELOR
Because your counselor does not work at MHCOC/COPE full-time, there will be many times when he/she is not available by telephone. If you need to contact your counselor, leave a message with the clinic staff at (662) 915-7197 and (s)he will give the message to your counselor. If your call is an emergency, contact one of the following:

Local Emergency Services: 911
National Suicide Prevention Lifeline: 1-800-273-8255

We do not provide emergency services.

Thank you for taking the time to read this. If you have any concerns or questions now, or at any point during your counseling, feel free to let your counselor know. You will receive a copy of this and have a chance to ask questions. You should keep your copy and refer to it throughout your counseling. Please sign below to indicate that you have read this and have had a chance to ask questions.

I have read this document, understand the information contained in it, and agree to participate in counseling under the conditions described.

_____ _____

(Type your full name if signing electronically) Date Client/Legal Guardian Signature Date

_____

Minor client if necessary Counselor-in-Training Date

THE UNIVERSITY of MISSISSIPPI

Mental Health Counselors on Campus at
Counselor Education Clinic for Outreach and Personal Enrichment

Consent for Videotaping Purposes

The Mental Health Counselors on Campus (MHCOC) at the Counselor Education Clinic for Outreach and Personal Enrichment (COPE) has been established to provide for children and their families. Our therapists have been trained to work with children and adults. An initial intake session will be conducted, at which time a therapist will be assigned.

All matters conducted at MHCOC/COPE are confidential and governed by the laws of HIPAA and the state of Mississippi. There are exceptions to confidentiality. If there is evidence of imminent danger of harm to yourself, your child, and/or others, a counselor is legally required to report this information to the appropriate authorities to insure the safety of everyone involved. Any case of suspected child abuse will be immediately reported to the department of human services, (DHS). We also must comply with any subpoenas received by a court of law. Any disclosures other than the ones mentioned in this form will require a consent form signed by the parent or legal guardian.

Our goals are to provide services to children and families. As a participant in these services offered by MHCOC/ COPE, we would like to request your permission to videotape you or your child's sessions.

Videotapes of counseling sessions have value as additional psychotherapy notes for the therapist. In the case where your child makes a disclosure of abuse, the video tape will be maintained for supporting your child's disclosure for legal purposes. Confidentiality will be maintained and only first names will be disclosed on the tape. Any professional who sees a videotape will be reminded of rules of confidentiality that prohibit discussion of the videotape.

By signing this document you understand and consent to the following:

1. The session will be taped and may be observed by supervisory personnel and counseling professionals for supervision.
2. You or your child's case may be discussed in professional staffing.
3. Information on you or your child's case may be subponaed by a judge.

By signing below, you are attesting that you have read and understand this document, and agree to the terms within.

_____ _____

(Client type your full name if signing electronically) Date

_____ _____

(Counselor type your full name if signing electronically) Date