COUNSELING/SUPPORT SERVICES
Telehealth Informed Consent

I,_____DOB:_____ , (name of student) hereby consent to participate in telehealth with **YES program Staff Members** as part of support services offered by **Yes Program Staff**.

I understand that telehealth is the practice of delivering clinical and other support services via technology assisted media or other electronic means between staff and student who are located in two separate locations.

I understand the following with respect to telehealth services:

1. I understand that I have the right to withdraw this consent at any time without affecting the right to future services or program benefits that I may be eligible for.
2. I understand I have agreed to proceed with the telephonic/video chat with the understanding that it may not be HIPAA compliant, given the restrictions imposed during the Covid-19 pandemic. I also understand there is a potential heightened risk to privacy, and a **limited ability to respond to emergencies**.
3. I understand that there will be no recording of any online sessions by any party. All information disclosed within sessions and written records are confidential and may not be disclosed without written authorization; except where disclosure is **permitted/required by law.**
    a. Should there be a concern for someone's safety:
        - Concern for student expressing suicidal ideation.
        - Concern for harm to others
        - Concern for the physical/sexual abuse of client or other.
        - Concerns for current issues of harassment, intimidation and bullying

4. When students participate in telehealth, we will ask for an **emergency contact**, as well as the current location **every time we speak** in order to provide for any unforeseen circumstances. **If there is a concern for a participant who may be in danger, steps will be taken to ensure their safety.**
5. **This consent will expire once we resume normal services**

EMERGENCY CONTACT NAME:_____

ADDRESS: _____

PHONE NUMBER: _____

_____ _____
Signature of Student/ Date

_____ _____
Signature of Legal Guardian Date
(if student is under age 16)

Verbal consent obtained on_____ Date by _____ (parent/ guardian or Student if age 16 or older for Clinical Services only) _____ Staff Member that obtained consent

E-mail the signed consent form back to Ms. Kristina Kcofone@trinitas.org