



College of the Sequoias Student Health Center
915 S. Mooney Blvd.
Visalia, CA 93277
(559) 730-3880

INFORMED CONSENT FOR TELEHEALTH SERVICES

CLIENT'S NAME: _____
Last Name, First Name

Telehealth is the mode of delivering health care via information and data communication technologies including, but not limited to, telephone and/or internet. Teletherapy includes consultation, diagnosis, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. Telehealth also involves the communication of medical/mental information, both orally and visually.

1. I have the right to withhold or withdraw consent (verbal or written) at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy.
3. I hereby agree to participate in telehealth counseling services through the College of the Sequoias Student Health Center. I further understand and agree to the *"Confidentiality Information, Reporting Information and Counseling Agreement"* information provided within the Triage Registration/Intake Form, including my right confidentiality and the legal exceptions to this right.
4. I understand there are risks and consequences from teletherapy, including, but not limited to the possibility, despite reasonable efforts on our part that: the transmission of information could be disrupted or distorted by technical failures; the transmission of information could be interrupted by unauthorized persons; and/or the electronic storage of medical information could be accessed by unauthorized person(s).
5. I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if COS Health Services staff believe I would be better served by another form of therapeutic services (e.g. face-to-face services), I may be assisted in securing a face-to-face appointment, or be referred to a professional who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite the efforts of my provider, my condition may not improve, and in some cases may even get worse.
6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
7. I accept that teletherapy does not provide emergency services, and if I am experiencing an emergency situation, I should call 911 or proceed to the nearest emergency room for help.
8. I understand that I am responsible for:
 - Providing the necessary computer, telecommunications equipment, and internet access for the teletherapy sessions.
 - The information security on my own computer or electronic device.
 - Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for the teletherapy session.
9. I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

10. I agree to hold harmless and indemnify the Trustees of the College of the Sequoias, the Governing Board, and it's respective officers, officials, employees, and agents from and against all losses, claims, demands, damages, alleged acts of malpractice, errors or omissions, and all costs and expenses incurred I, or resulting from my participating in the College of the Sequoias Health Center counseling sessions or counseling related activities. This includes liability which results from my own negligence.

I have read the foregoing policy statements and agree to these conditions.

Signature of Adult Client: _____ Date: _____

Witness: _____ Date: _____