OU Tulsa SCHUSTERMAN CENTER | STUDENT COUNSELING SERVICES

ADDENDUM AGREEMENT REGARDING SERVICES AND INFORMED CONSENT FOR **TELEHEALTH TREATMENT**

Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share individual client medical/psychological information for the purpose of providing mental health care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: client medical records, live two-way audio and video communication. Electronic systems used by OU-Tulsa Student Counseling Services ("SCS") will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Records of the telehealth encounter will be entered into SCS's electronic therapy record keeping system.

Expected Benefits

Use of telehealth services is intended to be temporary service provided as a response to the current COVID-19 pandemic. As such, the expected benefits include improved access to care and decreased need for travel and/or exposure to public space during the event, as well as a simple and efficient interface for maintaining therapeutic contact with a licensed counselor or individual operating under the license of a Licensed Health Service Psychologist.

Possible Risks

There are potential risks associated with the use of telehealth services. There is the possibility of interruption caused by technology failure, including equipment or connection problems. If the problems cannot be overcome during the timeframe of the scheduled session, that session will be rescheduled at the earliest convenience of both the counselor and the client. In some instances, the counselor may be available by phone to continue the session, though this is not guaranteed. While Zoom telehealth services provide encryption technology that is HIPAA compliant, confidentiality within telehealth sessions is a shared responsibility between the provider and the client. While providers may not disclose any client communications or information except as provided by HIPAA law and the OUHSC Notice of Privacy Practices, confidentiality is limited by the setting and environment of the individual receiving therapy and breaches by the client, intentional or unintentional, are not protected. Clients are required to utilize Zoom via the link provided to them from their counselor and/or required to use their official OU account with Zoom via login at ouhsc.zoom.us. Clients are further required to engage in telehealth services from a private location where they can attend the therapy uninterrupted by others for the full period of the scheduled session. SCS staff will not engage in telehealth services with an individual using Zoom from a non-OU account, nor will they continue a session if it is obvious the client is in a location where others may overhear or otherwise be privy to the session. Nonetheless, it is the responsibility of the individual receiving telehealth services to ensure confidentiality is maintained on the receiver's side of the interaction and such potential for breaches are not protected. With the use of telehealth technology, in very rare instances, security protocols could fail or partially fail causing a possible breach of personal health information.

Confidentiality with Mental Health Crises and Telehealth

Due to the specific constraints of telehealth counseling, your counselor will not have immediate access to you in the event of a mental health crisis during the course of a session. As part of ethical treatment, it is important that your counselor have a means of contacting you directly and/or connecting you with appropriate individuals (such as Emergency Medical Technicians, local police, etc.) to ensure your health and wellbeing as well as the health and wellbeing of those around you when there is a clear, imminent danger to yourself or others. Thus, to engage in telehealth therapy, **you must agree to provide your current location, address, and a contact phone number at the start of every telehealth session**. This information will be requested from you prior to being allowed to join the session and you will not be permitted to begin the session without providing the information. You may decline if you would prefer to cancel or reschedule your services for that day.

OVER

Authorization for Release/Use of Telehealth Services

Upon providing your signature to this document, you acknowledge that you understand and agree with the following:

1) I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to researchers or other entities without my written consent.
2) I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3) I understand the alternatives to telehealth consultation, which include receiving referrals to other counseling agencies in my community or in-person therapy as available at the SCS offices.
4) I understand that telehealth may involve electronic communication of my personal information to other mental health or medical practitioners who may be located in other areas, for the sole use of my mental health or medical treatment.
5) I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
6) I understand that portions of my healthcare information may be shared with other individuals for scheduling purposes. During times of technology failure, individuals other than my healthcare provider may have temporary access to the digital session to provide troubleshooting. When possible, opportunity will be given to me to verbally assent to the other individual's presence prior to them joining the session or, should I choose, to end the session early and reschedule at a later time when the technology is functional again. The above mentioned people will all maintain confidentiality of the information obtained.
7) I understand that I will be expected to either use the link provided to me by my counselor or access the session with my official OU account at ouhsc.zoom.us. I acknowledge that services will be denied to me if my counselor becomes aware that either of these conditions were not followed.
8) I understand that it is my responsibility to secure a private location to engage in telehealth therapy where I will not be interrupted or otherwise risk my confidentiality. I acknowledge that it is my responsibility to ensure confidentiality on my end of the telehealth connection and I will not hold SCS liable for breaches caused by my choice of location. I understand my therapist will do everything in their power to assist me in maintaining confidentiality and may prematurely end my session if they believe confidentiality is at risk.
9) I understand that Zoom is a HIPAA-compliant telehealth software, yet technology may fail and cause loss of session time or unintentional breaches of my personal health information, and that reasonable measures will be taken to safeguard against such outcomes.
10) I agree to not share my password for Zoom with others as unwanted access to my information may occur. I understand that SCS will not ask me for my password. The password is my sole responsibility for upkeep.
11) I understand that if I do not wish to sign this form, I may request in-person sessions at the OU-Tulsa Student Affairs offices. Continuance of in-person sessions will be based on current health and potential exposure to the COVID-19 virus pursuant to OUHSC health regulations.
12) I may revoke this Authorization at any time in writing by delivering my revocation to OU-Tulsa Student Affairs, 4502 E. 41st St. Room 1C76. Tulsa, OK 74135, but if I do, my revocation will not affect any release of information prior to OU's receiving the revocation.
13) I understand the information discussed during the use of telehealth services may indicate the presence of a communicable disease or non-communicable disease, mental health diagnosis, or substance use disorders.
14) I understand that this service of electronic communication and telehealth services is offered solely at the discretion of SCS and may be withdrawn at any time.

Certification

I hereby certify that I have read the contents of this form and have had the opportunity to ask any questions and obtain explanations to my satisfaction. I certify that I understand its content and significance. I further certify that all information requested during my evaluation is correct to the best of my knowledge. False information or information withheld could result in transfer or discharge. My signature acknowledges I have read this document carefully and understand the risks and benefits of the telehealth therapy and have had my questions regarding the procedure explained and I hereby give my informed consent to participate in a telehealth counseling utilizing Zoom under the terms described herein.

Signature of Client: _____ Date: _____