TELEMEDICINE INFORMED CONSENT FORM

I _____ (student's name) hereby consent to engage in telemedicine. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located within the North Dakota University System.

Because of recent advances in communication technology, the field of tele-therapy has evolved. It has allowed individuals who may not have local access to a mental health professional to use electronic means to receive services. Because it is relatively new, there is not a lot of research indicating that it is an effective means of receiving therapy. An important part of therapy is sitting face to face with an individual, where non-verbal communication (body signals) are readily available to both therapist and client. Without this information, tele-therapy may be slower to progress or less effective. It is important that you are aware that tele-therapy may or may not be as effective as in-person therapy and therefore we must pay close attention to your progress and periodically evaluate the effectiveness of this form of therapy.

With tele-therapy, there is the question of where is the therapy occurring – at the therapist's office or the location of the client? The student will receive services from a provider who is considered an extension of the local counseling office; therefore, these providers can communicate treatment plans and coordinate appointments without a release of information signed as outlined in the **Consent for Service** form.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the distribution of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Name: _____ Home campus: _____ Student ID#: _____

Signature: _____ Date: _____