WILLIAM PATERSON UNIVERSITY
COUNSELING, HEALTH & WELLNESS CENTER
OVERLOOK SOUTH
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CHWC Consent
Updated 2/6/2024

MEDICAL & COUNSELING CONSENT FOR TREATMENT & RELEASE

My signature below indicates acknowledgement that I have had a chance to read the **NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES AT THE COUNSELING, HEALTH & WELLNESS CENTER** for participation in **HEALTH & COUNSELING services including Telehealth**. I understand I may request a printed copy of this policy at any time.

I have had an opportunity to ask any questions I might have regarding the contents of this Notice. I understand its meaning and hereby give my consent to participate in health and counseling services based on the rights and responsibilities enumerated therein.

Participation in health services may include routine health examination, preventative measures, medical treatment, first aid and necessary referrals to outside healthcare providers.

Participation in counseling services may include consultations, triage, psychoeducation, therapy, development of treatment plan, necessary referrals to outside mental health providers and emergency evaluation at a hospital.

I understand that CHWC does not contract with all health insurers, and it is my responsibility to know if my health insurance provides coverage for CHWC lab services or requires a referral or pre-approval for such services.

I understand that I may be financially responsible for any co-pays, deductibles and/or co-insurance not covered by my health insurance for any lab services completed at CHWC.

I also consent to the release of pertinent medical records to appropriate health care providers and parents/guardians in the event of an emergency.

Medical Information and Records. All existing laws regarding your access to medical information and copies of your medical records apply to both in person and telehealth visits. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

Confidentiality. In accordance with applicable state and federal laws that protect the privacy of my personal health information and patient records, any information disclosed by me during the course of my care at CHWC will be kept as confidential. I understand that the dissemination of any personally identifiable images or information to other entities shall not occur without my written consent.

Limitations to Confidentiality. There are both mandatory and permissive exceptions to confidentiality. These exceptions include:

a) Where the counselor must disclose to authorities language or behavior consistent with wanting to hurt myself through suicide, with identifiable means, intent and plan,
b) Through expressed verbal, written or behavior threats of violence toward an ascertainable victim*, and/or*
c) Where the counselor must disclose to authorities my personal health information when abuse of a child or elder is suspected, on-going and/or intended child and/or elder abuse

Risks and Consequences. I understand that CHWC providers and staff will make every effort to protect my personal information. However, I understand that there are potential risks and consequences from telehealth. Some of these risk factors include, but are not limited to:

a) Transmission of my personal information while in session/appointment could be disrupted or distorted by technical failures,
b) The transmission of my personal information could be intercepted by unauthorized persons,
c) The electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.

TELEHEALTH CONSULTATION

Please note that CHWC takes great care to protect your personal information and utilizes secure audio/video transmission software to deliver telehealth.

During a Health Service consultation:
a) Details of your medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
b) Patient examination may take place via provider's assessment of symptoms.
c) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit for the purposes of training or assessment.

During a Counseling Service consultation:
a) Details of your health information may be shared with other staff within Counseling Health and Wellness Center for scheduling, supervisory consultation and/or medical consultation purposes.
b) Video, audio, and/or digital photo information may be recorded during a tele mental health visit when under the care of a supervised Graduate Counseling Intern.

I have read and understand the information provided above regarding health and counseling services, including the risks and benefits related to the use of telehealth services. I have had an opportunity to ask questions about this information and my questions have been answered. I hereby give my informed consent to participate in services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Student's Name ____ Student ID# 855_______________
(Please Print)

Student's Signature ____ Date ____/_____/_____

Parent/Guardian's Signature ____ Date ____/_____/_____
(Required FOR MEDICAL VISITS ONLY if the student is 17 years old or younger)

FOR OFFICE USE ONLY

Witness Signature ____ Date ___________

We attempted to obtain written consent for treatment and release but consent could not be obtained because:
_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the consent.
_____ An emergency situation prevented us from obtaining consent
_____ Other (Please Specify) ____

Name/Signature of Office Staff: ____