



Informed Consent for Teleservices

Student Name (printed)

Date of Birth

Banner ID #

I hereby consent to engage in teleservices. I understand that “teleservices” includes consultation, treatment, transfer of medical data, emails, telephone conversations, and education using interactive audio, video, or data communications. I understand that that teleservices also involves the communication of my medical/mental health information, both orally and/or visually.

I understand that I have the following rights and responsibilities with respect to teleservices:

1. I have the right to withhold or withdraw consent 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 teleservices. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential, with limited exceptions which are discussed in in detail in the SUNY BUFFALO STATE COUNSELING CENTER CONSENT FOR ASSESMENT AND TREATMENT FORM that I received with this consent form. Copies of these consent forms are available upon request.
3. I understand that there are always some risks with teleservices including, but not limited to, the possibility that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my information could be intercepted by unauthorized persons, and/or the electronic storage of my medical information could be accessed by unauthorized persons. Nobody will record the session without the permission from the others person(s).
4. I will provide an alternative communication method (most often phone) where I can be reached to restart the session or to reschedule it in the event of technical problems.
5. I agree to use Doxy.me, the video-conferencing platform selected for our virtual sessions. The Counseling Center will explain how to use it. I understand that these platforms have been approved by Buffalo State administration to use as a method of providing telehealth services. I understand if I have questions about this platform, I can contact Dr. Rock Doyle, Assistant Vice President of Health and Wellness, at (716) 878-6711.
6. It is important to use a secure internet connection rather than public/free Wi-Fi. Both my internet connection and the device should be password-protected. I need to use a webcam or smartphone to access video of the session.
7. I will be in a quiet, private space that is free of distractions (including turning off notifications on my cell phone or other devices) during the session.
8. I understand that teleservices are furnished in the state of New York, USA, and the services provided are governed by the laws of that state. I understand that teleservices delivered by my provider are required by law to take place within the state in which my provider is licensed, so I will be physically located in New York State while accessing teleservices at Buffalo State Counseling Center.
9. It is important to be on time. I will allow myself appropriate time before my session time to access teleservices. If I need to cancel or change my tele-appointment, I will notify the Counseling Center in advance by phone.

10. If I am under 18 years old, the Counseling Center needs the permission of my parent or legal guardian (and their contact information) for me to participate in teleservices services.
11. I understand that I may benefit from teleservices but that results cannot be guaranteed or assured. I understand that teleservices-based services and care may not be as complete as face-to-face services. I also understand that if my counselor determines I would be better served by another form of therapeutic services (e.g. face-to-face services), I will be referred to a professional who can provide such services in my area.
12. If my counselor is concerned about me, if contact is lost with me, or if I fail to show/communicate for scheduled teleservices, I will be contacted by phone or email (based on my noted preference) to check on my well-being. I agreed to provide my current location and permission to contact someone in order to ensure my safety in the event that I am showing signs of needing immediate assistance. If my counselor is unable to reach my emergency contact, or my emergency contact is unable to provide timely assistance to me, my counselor will contact a local crisis response agency to ensure my safety.
13. I accept that teleservices do not include emergency services. During our first consultation, my counselor and I will discuss an emergency response plan. In the event of a crisis situation, we will confirm a safety plan that includes my current location, at least one emergency contact, and the closest ER to my location. If I am experiencing an emergency situation, I understand that the protocol will be to call 911 (off campus) or 878-6333 (on campus) or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself or someone else, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support.

EMERGENCY CONTACT IN YOUR LOCATION:

Emergency Contact Name	Phone number	Relationship to student
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I have read, understand, and agree to the information provided above.

NOTE: If you do not agree to participate in teleservices, please do NOT sign this form - call the Counselor Center at 716-878-4436 to be referred to other services.

Typing my full legal name (after “/s/”) and date below constitutes my signature:

Signature of Patient: /s/_____ Date: _____

Once signed, this form can be returned via email to counselingcenter@buffalostate.edu or via mail to the fax/address above. Confidentiality of email cannot be guaranteed, as e-mail is not a 100% secure medium.