ALHAMBRA UNIFIED SCHOOL DISTRICT

Alhambra Unified School District
1515 W Mission Rd, Alhambra, CA 91803 (626) 943-3410
Informed Consent for Gateway To Success Services

CONSENT FOR TELEHEALTH SERVICES

The purpose of this consent form is to provide students and guardians with information that is important to consider when deciding whether to continue their existing counseling services by means of telehealth or telephone. In order to provide flexibility to families counseling services will be provided in a combination of consultation with teachers and parents, telehealth sessions with students, emailed assignments with learning projects or reflections, and/or email check-ins if the client and therapist are unable to proceed with sessions in person.

What are Telehealth services and when are they used?
Telehealth services are used when mental health staff cannot be physically present with you to evaluate your mental health needs and provide weekly sessions. Mental health staff may be present at another location and available to serve you through newly available technology. Instead of talking to someone on the phone at another location, Telehealth services use a video camera and computer to send both voice and personal images (pictures) between you and mental health staff so not only can you talk to each other, but you can also see each other. This allows mental health staff to make a better evaluation of your needs.

How do Telehealth services work?
You will be in a private room either by yourself, with a friend, family member, or staff person. The room will have a computer with a video camera. The mental health staff will also be in a private room but at another location with the same type of equipment. When the session is ready to begin, clinic staff will start the computer and camera so that you and mental health staff can see each other and talk together. When the session is over, clinic staff will shut off the equipment.

How is it different from a regular session with mental health staff?
Other than you and mental health staff not being in a room together, there is very little difference in the session. Mental health staff will ask and document clinical information that you share with him/her, document the service that is provided, and ensure that documentation is included in your clinical record for future reference.

What happens if I choose not to consent to Telehealth Services?
If you choose not to consent to Telehealth services, we will be unable to provide you with convenient and readily available services and your services will be terminated.

Resources for Social Emotional Learning and more on AUSD Gateway Website at: ausdgateway.com

Hotlines
- 1-877-7-CRISIS (Toll free 24/7 LA County)
- 1-800-273-TALK (Toll free, 24/7 Nationwide)
- 1-800-SUICIDE (Toll free, 24/7 Nationwide) 1-800-784-2433
- Domestic Violence Hotline: (562)945-3939
- L.A. County Child Abuse Hotline: 1 (800) 540-4000
- National Sexual Assault Hotline: 1-800.656.HOPE (4673)

Suicide Prevention Websites
- Centers for Disease Control – cdc.gov
- National Association of School Psychologists – nasponline.org
- Suicide Prevention Lifeline (English/Spanish/Deaf)- https://suicidepreventionlifeline.org/

CONSENT FOR TELEHEALTH SERVICES

By signing this form, I attest to and understand the following:

1) I understand that the privacy laws that protect the confidentiality of counseling sessions also apply to tele-support unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; court subpoena).

2) I understand that Visual or audio recording of the communication are not allowed either by the mental health care provider, the student, or the parent/guardian. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

3) While telehealth therapy will be conducted primarily through secure and private videoconferencing, I understand that there are always some risks with telehealth services including, but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

4) I understand that telehealth services are furnished in the state of California, USA. Should the student relocate outside of California, the services provided are governed by the laws of that state.

5) I will work with my counselor to identify an alternative communication method (most often phone) in the event that the videoconferencing tool fails.

6) I will be responsible for the following: (1) providing the computer and/or necessary telecommunications equipment and internet access (2) arranging a location that is confidential for my child's or my (adolescent) telehealth sessions.

7) I understand that if the counselor/intern is concerned about my child or me or we lose contact, or if my child/I fail to show for a scheduled videoconference, the counselor/intern will contact me by phone to check on our well-being. In addition, if my child or I am showing signs of being in danger, I understand AUSD is required to contact authorities to ensure our safety.

8) I understand that I may expect the anticipated benefits from the use of Telehealth counseling in my care, but that no results can be guaranteed or assured.

Specific to Counseling Groups (if applicable):

All existing confidentiality rules for group sessions apply. However, given that other group members will also be participating from a remote location, it is possible that your child's confidentiality could not be maintained if other members are not in a private area.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and FERPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.

___ **Yes, I consent:** I have read and understand the information provided above regarding telehealth Counseling services and I hereby give my informed consent. I understand that I have the right to withdraw consent at any time without affecting my child's right to future services.

___ **No, I decline** to have my child participate in telehealth counseling and request alternative activities that are related to his/her goals such as recommended apps, resources, etc. and will contact you if I change my mind.

Parent/Guardian Name: ___________________________________

Parent Signature: ____ Date: ______________

*** An email reply indicating consent shall serve as an electronic signature during stay-at-home restrictions, per guidance from the Los Angeles County Office of Education.*

□ Phone consent: Parent/guardian understands the above advisements and has verbally consented to accept sessions via tele-support but is not signing this Consent Addendum due to procedures in place in response to the public health crisis.

_____________________________________ _________________________________

Name / Title of AUSD Gateway Staff | Signature / Date of phone contact

Contact Information for telehealth Counseling Provider:

Name/Title:		I will respond to emails during these office hours:
Email:		

A close personal contact such as another caregiver or family member in the household in the event I cannot be reached:

1. ___________________________________ ____________________

Name/Relationship | Contact number

2. ___________________________________ ____________________

Name/Relationship | Contact number

3. ___________________________________ ____________________

Name/Relationship | Contact number

____ __________________

Parent/Guardian Signature | Date

____ __________________

Student Signature | Date