CONSENT TO ENGAGE IN TELECONFERENCING WITH OUTAGAMIE COUNTY & WAIVER OF CONFIDENTIALITY

1. OVERVIEW:
   
a. The purpose of this document is to obtain consent for Teleconference Services with Outagamie County Health & Human Services (OCDHHS). Given the recent outbreak of COVID-19, the Governor’s Executive Order #12 Safer at Home, and Outagamie County’s continuing duty to have face to face contact with certain clients, Outagamie County has contracted for the ability to perform face to face contact via teleconference.

b. Teleconferencing service is the delivery of services when the social worker/therapist/case manager and consumer are not in the same physical location/site but can see and or hear the client through the use of various technology. This could include video sessions via software on a computer or tablet, or phone. In the event that video sessions are not available teleconferencing may have to occur via phone.

c. To allow for these teleconferences to occur, the County has contracted with “Zoom” in order to complete teleconferences. First, although we believe Zoom is a secure platform with industry-standard encryption and security, there is no way to guarantee that this software is completely secure. As with any technology, there is a chance of a security breach that would affect the privacy of personal and/or medical information. Second, since you will be completing sessions in your own home, we cannot guarantee the same level of privacy that you have when you are in our office. This means that you are responsible for making sure that you are in a private area where disruptions (e.g., others coming into the room or hearing what you say in another room) are minimized as much as possible. Third, in the event of group sessions conducted via video, it is possible that your confidentiality could be breached if others in the group are not in a confidential setting. Finally, by agreeing to utilize Zoom as a medium to communicate with staff at Outagamie County, there are potential risks that Zoom will retain data including but not limited to, your identity and the connection to Outagamie County. To view Zoom’s privacy policy and the potential information which may be disclosed to Zoom please visit https://zoom.us/privacy.

2. REQUIRED ACTIONS BY CLIENT: The following are steps which must be taken if a client wishes to engage in a Zoom conference with an Outagamie County Employee:

   a. In order to reduce risks to confidentiality, all video or telephone sessions must occur in a private room with no one else present unless others are required by OCDHHS. In addition, wear headphones to limit the possibility of other people overhearing confidential information if possible.

   b. In the event, that you want a third party to participate either in person with you, or via their own link to the video conferencing session, you must identify the individual you wish to include along with their contact information. By including a third party in this section, you acknowledge and waive all requirements that the County maintain confidentiality and/or professional privileges which exist under State or Federal law with the individual you are allowing to participate.

      i. The Third Party or Parties I wish to Include is/are ____________________________, and their contact information is as follows: ____________________________

   c. Certain information discussed in these sessions may qualify as protected health information which is protected under the Health Insurance Portability and Accountability Act (HIPAA), Wisconsin Stat. Chapter §§146.82, 48, and/or 51.30. In order to utilize Zoom to communicate with the County you must sign this document waiving these rights.
3. WAIVERS AND RELEASES: BY SIGNING THIS FORM, YOU CERTIFY YOU UNDERSTAND, ACKNOWLEDGE, AND AGREE TO THE FOLLOWING TERMS:

a. YOU ARE SEEKING TO PARTICIPATE IN A TELECONFERENCE MEETING BETWEEN AN OUTAGAMIE COUNTY EMPLOYEE AND YOURSELF AS A CLIENT OF OUTAGAMIE COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES.

b. YOU UNDERSTAND THAT THE SOCIAL WORKER/THERAPIST/CASE MANAGER WILL BE AT A DIFFERENT LOCATION FROM YOU AND WILL BE COMMUNICATING WITH YOU VIA TELEPHONIC MEANS OR AN INTERNET BASED PROGRAM, ZOOM.

c. YOU UNDERSTAND THAT YOU HAVE THE RIGHT TO WITHHOLD OR WITHDRAW YOUR CONSENT TO THE USE OF TELECONFERENCING SERVICES AT ANY TIME IN THE COURSE OF YOUR CARE, WITHOUT AFFECTING YOUR RIGHT TO FUTURE CARE OR TREATMENT.

d. YOU HAVE BEEN INFORMED OF AND ACCEPT THE POTENTIAL RISKS ASSOCIATED WITH TELEHEALTH, SUCH AS FAILURE OF SECURITY PROTOCOLS THAT MAY CAUSE A BREACH OF PRIVACY OF PERSONAL AND/OR MEDICAL INFORMATION.

e. YOU HAVE FURTHER BEEN INFORMED OF AND ACCEPT BY INITIALING ALONG SIDE EACH THE POTENTIAL FOR ZOOM TO OBTAIN AND RETAIN INFORMATION REGARDING YOURSELF, OUTAGAMIE COUNTY, AND ANY THIRD PARTY YOU ALLOW TO PARTICIPATE INCLUDING THE FOLLOWING:

   Client shall initial next to each item that could be discussed during session

   i. Medical Information _____

   ii. Mental Health Information_____ 

   iii. Treatment Records ______

   iv. Juvenile Records for yourself/your children ______

   v. Financial Information _______

   vi. Test Results ______

   vii. Psychotherapy or Psychiatric Records _______

   viii. OTHER _____________________________. _________

f. If there are records you do not wish to be released, specify here: _____________________________.

g. KNOWING THIS YOU ARE CONSENTING TO THIS AGREEMENT AND WAIVING ANY RIGHTS TO CONFIDENTIALITY OR PROFESSIONAL PRIVILEGE BETWEEN YOURSELF, OUTAGAMIE COUNTY, AND ZOOM.

h. YOU FURTHER ACKNOWLEDGE AND WAIVE BOTH YOUR RIGHTS TO CONFIDENTIALITY AND PROFESSIONAL PRIVILEGES TO ANY INDIVIDUAL YOU ALLOW TO BE PRESENT DURING THE COURSE OF YOUR TELECONFERENCE, WHETHER THEY APPEAR AS A PARTY TO THE TELECONFERENCE REMOTELY, OR WITH YOU IN PERSON. IN THE EVENT YOU DO NOT WANT INDIVIDUALS PARTICIPATING AT YOUR LOCATION, YOU WILL ENSURE YOUR PRIVACY AT THE LOCATION FROM WHICH YOU ARE PARTICIPATING. IF YOU DO NOT TAKE SUCH SAFEGUARDS TO MAINTAIN YOUR PRIVACY YOU FULLY ACCEPT AND ASSUME THE RISK OF PARTICIPATING IN THE TELECONFERENCE.
i. YOU HAVE BEEN GIVEN THE OPPORTUNITY TO ASK YOUR PROVIDER AT OCDHHS QUESTIONS RELATIVE TO YOUR TELECONFERENCE, SECURITY PRACTICES, TECHNICAL SPECIFICATIONS, AND OTHER RELATED RISKS. THAT YOU HAVE READ OR HAD READ AND/OR HAD THIS FORM EXPLAINED TO YOU;

j. THAT YOU FULLY UNDERSTAND ITS CONTENTS INCLUDING THE RISKS AND BENEFITS OF TELECONFERENCE SERVICES.

K. I HEREBY CONSENT TO RECEIVE TREATMENT REMOTELY RATHER THAN IN PERSON.


_____________________________________   __________________
Signature of Participant      Date

_____________________________________
Printed name of Participant

_____________________________________   _________________
Signature of Person Obtaining Consent     Date

_____________________________________
Name of Person Obtaining Consent