Welcome to UT Health San Antonio TCHATT!

What is TCHATT?

TCHATT (Texas Child Health Access Through Telemedicine), is a partnership between UT Health San Antonio and the State of Texas. We provide FREE mental and behavioral healthcare services for students and their family within partnering school districts. Students will receive ***short-term interventions*** and referrals will be made if long-term services are needed. *Please note all services are telemedicine, meaning they are video visits and are* ***NOT*** *in-person.*

Please complete and return the following forms & documents:

Once your Proxy Form has been processed, you will receive an email with a MyChart Activation Link. After you have activated your MyChart account, we will then contact you to schedule your child's appointment.

- ❑ Under 18 Proxy Form……(Page 2)
- ❑ Release of Information Forms……(Pages 3,4)
- ❑ Patient Information Form……(Page 5)
- ❑ No Show/Missed Appointment Policy Form……(Page 6)
- ❑ Email Authorization Agreement……(Pages 7,8)
- ❑ Student Group Visit Consent Form **(if applicable)**……(Page 9)
- ❑ Copy, photo, or scan of Identification card (ID) or Driver's License
- ❑ Copy, PDF, or scan of legal documentation proving legal guardianship **(if applicable)**
- ❑ Copy, PDF, or scan of divorce decree/court order **(in situations involving divorced parents or court ordered custody agreements)**
- ❑ TRAYT Intake Form: This will be sent to your email address once your packet is received, and it must be completed prior to your first appointment.

Return these forms and required documents to TCHATT via:

Online Secure Link or DocuSign **(if applicable)**
OR
Fax: 210-450-2450

UT Health San Antonio
The University of Texas Health Science Center at San Antonio

My Chart®

Child Under 18 Proxy Request Form

This form should be completed by a parent or legal guardian ("Proxy") who requests access to portions of his/her child's (under 18 yrs.) Electronic Protected Health Information maintained by UT Health Science Center - UT Health of San Antonio and/or any of their affiliated clinics through My Chart. The Parent/Legal Guardian "Proxy" must agree to and comply with the terms and conditions of the My Chart webpage and this document. Proxy must complete all fields and provide photo ID and legal documents (if permanent Legal Guardian of the Patient) as noted below.

Child's ("Patient Information"): All sections required - please print clearly

Patient's Name		DOB:			
Street Address					
Phone Number					
City:		State:		Zip:	

Parent/Legal Guardian ("Proxy") Information: All sections required - please print clearly

Email Address					
Proxy's Name:		DOB:			
Street Address:					
Phone Number:					
City:		State:		Zip:	

My Relationship to the Child is as Follows:

☐ Parent ☐ Custodial Parent ☐ Non-Custodial Parent

OR

☐ Permanent Legal Guardian - Must attach a copy of the court order appointing guardian and letter of Guardianship verifying the proxy's status as permanent Legal Guardian of the Patient

I acknowledge and agree that:

1. I will comply with the terms and conditions on the MyChart web page and this document. If I am the permanent legal guardian for this patient, I have the proper documentation that authorizes this, thereby allowing me access to his/her protected health information through MyChart.
2. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expired, I must immediately notify this institution in writing of the revocation, termination or expiration and mail to: UT Medicine of San Antonio, Health Information Management Department, 8300 Floyd Curl Drive - MC 8308, San Antonio, Texas 78229
3. I understand that MyChart is intended as a secure online source of confidential medical information. If I share my MyChart ID and password with another person, that person may be able to view my child's health information as a MyChart Proxy.
4. I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe confidentiality may have been compromised in any way.
5. I understand that it is my responsibility to ensure that my e-mail address is current at all times, and that if my email address is not current, I will not receive important messages from MyChart.
6. I understand that MyChart contains selected, limited medical information and that MyChart does not reflect the complete contents of the electronic medical record, I also understand that a copy of my child's electronic medical record may be requested from The Health Information Management Department
7. For a child age 0-17 years, I will be granted full access to my child's MyChart record.
8. On the child's 18th birthday, I will no longer have access to my child's MyChart record.
9. I have completed the MyChart Authorization for Use or Disclosure of Electronic Protected Health Information.

Proxy Signature (Required)	Relationship to Child (Required)	Date (Required)	Time (Required)
	/	/	/

University of Texas Health Science Center
8300 Floyd Curl, MC 8308
San Antonio, Texas 78229
Phone: 210-450-9760
Fax: 210-450-6058

Authorization for Release of Health Records to External Parties

1. I authorize **UT Health San Antonio, Texas Child Health Access Through Telemedicine (TCHATT)** to disclose information from the health records of:

   Patient Name: _____

   MRN #: _____ Date of Birth: _____

2. **The information is to be disclosed to**: _***Current School District:*** _____

   Address (sender/receiver if other than UT Health Physicians): _____

   City, State, Zip: _____

   Contact Person: _____

   Phone/Fax: _____

   I authorize this information to be disclosed in the following ways:

   ❑ Written/Photocopy/Paper ❑ Verbal ❑ Fax ❑ Electronic Mail *

   Purpose of the disclosure: ***To support the patient in the school setting***

3. **Dates of Treatment:** From: _____ to: _____

Specific reports to be disclosed:

❑ Progress Notes ❑ Laboratory Reports ❑ Operative Reports
❑ Discharge Summary ❑ Radiology Reports ❑ Consultation Reports
❑ X-ray films or other images ❑ Photographs/Videotapes ❑ Records from other facilities
❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
❑ Other (Specify): ***Limited Health Records: Information regarding TCHATT evaluation or treatment***

I give specific authorization to disclose the following information:

❑ HIV test results ❑ Documentation of AIDS diagnosis
❑ Drug and alcohol abuse treatment records ❑ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying UT Health Physicians in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient

*Note: Release of Psychotherapy notes requires a separate authorization

Revised 05/2017

University of Texas Health Science Center
8300 Floyd Curl MC 8308
San Antonio, Texas 78229
Phone: 210-450-9760 Fax: 210-450-6058

Authorization for Release of Health Records to External Parties

1. I authorize **University of Texas Health Science Center at San Antonio** to disclose information from the health records of:

   Patient Name: _____

   MRN #:_____Date of Birth: _____

2. **The information is to be disclosed to**: ***Pediatrician/Primary Care Practitioner Name:*** _____

   Address (sender/receiver if other than UT Health Physicians):_____

   City, State, Zip: _____

   Contact Person: _____

   Phone/Fax: _____

   I authorize this information to be disclosed in the following ways:
   ❑ Written/Photocopy/Paper ❑ Verbal ❑ Fax ❑ Electronic Mail *

   Purpose of the disclosure: ***Coordination of TCHATT care with Pediatrician/PCP*** _____

3. **Dates of Treatment:** From: _____ to: _____

   Specific reports to be disclosed:
   ❑ Progress Notes ❑ Laboratory Reports ❑ Operative Reports
   ❑ Discharge Summary ❑ Radiology Reports ❑ Consultation Reports
   ❑ X-ray films or other images ❑ Photographs/Videotapes ❑ Records from other facilities
   ❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
   ❑ Other(Specify):_____

   I give specific authorization to disclose the following information:
   ❑ HIV test results ❑ Documentation of AIDS diagnosis
   ❑ Drug and alcohol abuse treatment records ❑ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying UT Health Physicians in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient

*Note: Release of Psychotherapy notes requires a separate authorization

Revised 05/2017

UT Health San Antonio

TCHATT Texas Child Health Access Through Telemedicine

PATIENT INFORMATION:

Name: (Last) _____ (First)_____(M.I.)_____

Date of Birth: _____ Social Security #: _____ Sex:

Street Address: _____ (Apt #) _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Grade: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

PARENT/GUARDIAN INFORMATION:

Father's/Guardian Name:_____ DOB:_____ SS#:_____

Cell Phone _____ Work Phone: _____ Home Phone: _____

Email: _____

Mother's/Guardian Name: _____ DOB: _____ SS#: _____

Cell Phone _____ Work Phone: _____ Home Phone: _____

Email: _____

Parent's Relationship Status:

Please provide copy of divorce decree or court order in situations of divorce, separation, or court ordered custody agreements

Guardian's Relationship to Patient:

INSURANCE SUBSCRIBER:

Required for medication services or long-term care referrals only (if applicable).

Policy Holder Name:_____ DOB:_____ SS#:_____

Insurance Name: _____Insurance ID#: _____Group #:_____

Relationship to patient: _____ Employer: _____

Work Phone:_____ Address:_____ City:_____ State:_____ Zip Code:_____

PRIMARY CARE PROVIDER:

Physician Name: _____ Office Number: _____

Address:_____ City:_____ State:_____ Zip Code:_____

PHARMACY:

Pharmacy Name: _____ Phone: _____

EMERGENCY CONTACT:

Name of person not living with you: _____ Relationship: _____

Cell phone: _____Home phone: _____Work Phone: _____

Parent Name: _____Signature: _____ Date:_____

NO-SHOW/MISSED APPOINTMENT POLICY

Thank you for trusting TCHATT with your Psychiatric and Behavioral Healthcare services. We understand that there are emergencies or that you may need to cancel or reschedule an appointment.

Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No-Show Policy below:

If less than a 24-hour cancellation is given, this will be documented as a "No-Show" appointment:

For New Patient Visits:

- First No-Show or cancellation/reschedule without 24-hour notice, the patient may be rescheduled and reminded of the policy.
- Second No-Show or cancellation/reschedule without 24-hour notice, the patient may be dismissed from TCHATT.

For Follow Up Visits:

- First No-Show or cancellation/reschedule without 24-hour notice, the patient may be rescheduled and reminded of the policy.
- Second No-Show or cancellation/reschedule without 24-hour notice, all scheduled follow-ups may be cancelled, and the patient will need to call back to reschedule.
- Third No-Show or cancellation/reschedule without 24-hour notice, the patient may be dismissed from TCHATT.

To ensure that each patient is provided the allotted scheduled time for their visit, and to provide the highest quality of care, it is very important to be on time for each scheduled appointment. Please arrive 15 minutes prior to your scheduled appointment.

As a courtesy, an appointment reminder call is made to you through our automated system two business days prior to your appointment. If you are still unsure of your appointment date or time, please contact us. It is the responsibility of the patient to arrive for their appointment on time. Please keep in mind, even if you do not receive a reminder call or message, the above Policy will remain in effect. We are here to help.

Thank you for using TCHATT, and we look forward to serving you!

Patient Name:_____ **DOB:**_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ **Date:**_____

E-mail Authorization Agreement

UT Health San Antonio offers patients the ability to communicate with healthcare providers via electronic mail (e-mail) for non-urgent matters through a secured mechanism. Both you, the patient, and your provider have to agree to this arrangement. ***No information is ever sent electronically without permission given by you or your legally authorized representative.***

Appropriate uses for e-mail

E-mail may be used to request information and ask non-urgent questions. It should not be used in emergencies. If you are experiencing a sudden or severe change in your health or otherwise need an immediate response, please contact your healthcare provider's office by telephone, call 911, or go to an emergency room.

E-mail may be used to send protected personal health information for:

- Prescriptions/refills
- General medical advice after an initial face-to-face visit
- Lab test results
- Patient educational material

Secure e-mail mechanism

Once we have received your permission, your provider will send an e-mail to a secure location. You will receive an e-mail telling you that the provider has left you a message. In the e-mail there will be a link to click on. This link will take you directly to the e-mail message. The risk associated with this e-mail mechanism is if others have access to your e-mail, they will have the ability to click on the link and will be able to view the information.

If you have an e-mail address and would like to take advantage of this service, please discuss your wishes with your healthcare provider (e.g., doctor) first. Some providers do not communicate with their patients electronically. Others may ask an associate such as a nurse or billing person to contact you, based on your e-mail request.

UT Health San Antonio may forward e-mails as appropriate for diagnosis, treatment, and other related reasons. As such, UT Health San Antonio staff, other than your provider, may have access to e-mails that you send. Such access is only to make available healthcare services to you. Otherwise, UT Health San Antonio will not forward e-mails to any one else without your prior written consent, except as authorized or required by law.

Keeping records of e-mail communications

E-mail communications will be documented in one of two ways: (1) an electronic note maintained in a computer system and/or (2) a paper copy filed in your medical record.

Sending e-mail

Please include your full name and your medical record number in every e-mail message that you send to your healthcare provider. This information is required so the provider can establish that the person requesting medical advice is in fact the person the sender claims to be. Without this information, the physician will not be able to address your questions. The subject line should include the purpose of the e-mail, for example: "Prescription Refill Request".

When you receive a message from your provider containing medical advice, please acknowledge the message by sending a brief reply to the provider.

If a message is ever returned because of a "bad address" please make sure that you entered the complete address as it was given to you. If you are sure that you entered the address the provider gave to you, please call the provider's office and make sure you have the correct e-mail address and that the computer system is functioning properly.

If your healthcare provider does not answer your e-mail in 2-3 days contact the office by telephone.

E-mail Authorization Agreement

UT Health San Antonio may choose to discontinue e-mail communication at any time.

Privacy and security of e-mail

Do not use e-mail to send or request sensitive information. This includes personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use e-mail provided by your employer, any e-mail sent on your employer's system may be viewed by your employer.

UT Health San Antonio cannot and does not guarantee the privacy or security of any messages being sent over the Internet. There is the potential that e-mail sent over the Internet can be intercepted and read by others. If this is of concern to you, you should not communicate with your healthcare provider through e-mail.

This document along with UT Health San Antonio's "Notice of Privacy Practices" constitutes a notice of privacy practices for e-mail use as required by the Texas State Board of Medical Examiners.

Authorization to use e-mail

I have been informed of and understand the risks and procedures involved with using e-mail. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of e-mail as one form of communication with my physician, and his/her associates, technicians and other heath care providers.

You will be given a copy of this signed form to keep for your records.

Patient E-mail Address

Patient Signature _____ Date _____

Patient Representative (Relationship) _____ Date _____

Clinic Manager/Clinic Supervisor _____ Date _____

Patient Label

NOTICE OF MEDICAL INFORMATION DISCLOSURE IN THE GROUP VISIT UT Health San Antonio TCHATT

I understand that by my child participating in a group visit:

- Personal information that my child shares may be heard by other group participants andtrainees, including students. Some information may be medical information, which may normally be considered protected health information.

- I have been notified of the potential disclosure of personal information, and I voluntarily wish for my child to participate in the group visit.

_____

Name of child participating in group

_____

Name of parent

_____

Parent signature

_____

Date

CPAN
Child Psychiatry Access Network

After TCHATT, follow up with your Pediatrician.

Your pediatrician is able to support your child's mental healthcare needs. The Child Psychiatry Access Network (CPAN) serves to empower and equip pediatricians to manage mental healthcare treatment.

Your local CPAN team is here to help ensure your child's long-term mental and behavioral healthcare success!

Please provide this flyer to your pediatrician and ask them to contact CPAN: 1-888-901- CPAN (2726) option 3 then 2.

CPAN offers FREE services to Pediatricians:

Telephone clinical consultation for pediatricians during business hours with a child psychiatrist or mental health clinician.

Care coordination for assistance with referrals to community mental health services.

UT Health San Antonio CPAN Team

UT Health San Antonio

TCHATT Texas Child Health Access Through Telemedicine

tcmhcc