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TELEMEDICINE CONSENT FORM

Introduction:

Telehealth involves the use of electronic communications to enable providers at different locations to share individual client information for the purpose of improving client care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Client health records
- Live two-way audio and video
- Output data from health devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Possible Risks:

There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the provider and consultant(s);
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information;
- In rare cases, a lack of access to complete health records may result in interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

- 3. I understand that a variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
- 4. I understand that telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.
- 5. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
- 6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
- 7. I understand that the patient MUST be present during the telemedicine visit.

I understand that by signing this form that I am consenting to receive health care services via telemedicine.

_____ Date of Birth: _____
Patient's Name (print)

Print Patient or Parent/Legal Guardian Name (if minor)

_____ Today's Date: _____
Signature of Patient or Parent/Legal Guardian (if minor)