Authorization and Informed Consent for Telehealth Consultation

Patient Name: _____ Date: _____

DOB: _____ MRN #: _____

During the telehealth consultation:

- Details of your medical history, examinations, x-rays, and tests may be discussed with other health professionals using interactive video (live two-way audio and video), audio and telecommunications technology.
- Visual and physical examination of you may take place.
- Nonmedical technical personnel may be requested to enter the area where telehealth is being performed.
- Video, audio, and/or photo recordings may be taken of the encounter(s).

EXPECTED BENEFITS:

Improved access to medical care by enabling a patient to remain in his/her facility or home and consult with healthcare practitioners at distant/other sites to reduce risk of exposure and potential harm to the patient and community. More efficient medical evaluation and management.

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 enough (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
- Delays in medical 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 medical information.
- I understand there are limitations to the technology and the process of telehealth, including the potential for incomplete exchange or loss of information.

PRIVACY AND SECURITY

All existing laws regarding privacy and security of your health information and copies of your medical records apply to this telehealth health service and the audio and video information transmitted, received and stored electronically as part of this service.

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

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical 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 during my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded during a telehealth interaction and may receive copies of this information for a reasonable fee.
4. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be in other areas, including out of state.
5. 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.

PATIENT CONSENT TO THE USE OF TELEHEALTH:

I have read and understand the information provided above regarding telehealth, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care.

I hereby authorize providers _____ (**Facility Name**) to use telehealth during my diagnosis and treatment.

_____ _____

Patient/Guardian Printed Name **Relation to Patient**

_____ _____

Patient/Guardian Signature **Date**