TELEHEALTH INFORMED CONSENT

Telehealth (also called telemedicine) is a way to visit with your healthcare provider without going to a hospital or clinic. The visits are held by computer, tablet, or telephone.

This form gives permission for telehealth communication between _____
(Healthcare provider's name)

and _____ _____
(Patient's name) (Patient's date of birth)

Patient's Initials

____ I understand that telehealth involves sharing my medical/mental health information electronically. I will tell my healthcare provider if there is any information that I do not want to talk about in a telehealth visit.

____ I understand that I may stop the telehealth visit at any time. If I decide to stop, I will still be able to have medical care at this office.

_____ I understand that I may have to check with my health insurance plan to see if telehealth visits are covered.

_____ I understand that telehealth visits carry some level of risk. These risks include but are not limited to:

- My computer, tablet, or phone may not be private and secure, especially if other people use it. It is my responsibility to make sure my internet system is private and secure and to make sure I am in a private place during the visit.
- Technical problems may interrupt or stop the visit before it is done.
- My healthcare provider cannot examine me as closely during a telehealth visit, and this may make it harder to determine what is wrong with me.

_____ I agree that information shared during my telehealth visit will be kept by the healthcare providers and facilities involved in my care.

_____ I understand that the telehealth visit will or will not (circle one) be recorded.

_____ I understand that I will be asked to confirm my identity and current location to the healthcare provider seeing me.

_____ I also have the right to confirm the identity and credentials of the healthcare provider who will be seeing me.

_____ I agree to follow my healthcare provider's recommendations—including lab tests and x-rays, sending me to a specialist, or asking me to come to the office or go to an emergency department for an in-person visit.

By signing below, I agree that we talked about the information on this form, my questions have been answered, and I want to have a telehealth visit.

Patient or Legal Representative Signature/Date/Time

Print Patient's or Legal Representative's Name

Patient's Date of Birth

Legal Representative's Relationship to Patient

Witness Signature/Date/Time

Print Witness's Name

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Healthcare Provider Signature/Date/Time