[practice logo]

CONSENT TO ENGAGE IN TELEHEALTH AND TELEMEDICINE

1. I, _____, consent to engage in telehealth and telemedicine with [Entity/Provider]. At the time of the telehealth and telemedicine appointment (the "appointment"), I will be located in _____ (identify state of location).

2. [Entity/Provider] has explained to me how the technology used during the appointment works and will be used.

3. During the telehealth and telemedicine appointment:

    a. Details of your medical history, medical records, examinations, x-rays, and tests will be discussed through the use of interactive video, audio, and/or telecommunication technology, if video is possible and your medical information is available.
    b. A physical examination of you may take place although limited to what can be seen through video if video is possible.
    c. Other licensed medical professionals may be present during the appointment.
    d. Other non-medical staff may be present during the appointment to assist with the technology, but you may request for that non-medical staff to leave the room before continuing the appointment.
    e. Video and audio recordings, and or photographs, may be taken of you during the appointment, if video and photographs are possible.

4. I acknowledge that I verbally provided [Entity/Provider] with a complete medical history either before or during my scheduled telehealth and telemedicine appointment with [Entity/Provider], and I provided medical records through [Enity/Provider] portal [name of HIPAA compliant program] if I had those medical records available and was able to submit them to the [Entity/Provider] through the portal.

5. I understand that there are certain risks in using telehealth and telemedicine including, but not limited to, the following:

    a. Information transmitted may not be sufficient due to poor or inadequate quality to allow for appropriate medical decision thus necessitating a face-to-face visit or at least a rescheduled video consult.
    b. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
    c. Even with the use of [Entity/Provider's] portal [name of HIPAA compliant program], security protocols could fail, causing a breach of your privacy of personal medical information and disclosure to third parties.

6. I understand that no results have been or can be guaranteed.

7. If I have an adverse reaction to the treatment provided to me via telehealth and telemedicine, I will immediately contact your office, unless it is an emergency. If it is an emergency, I will contact 9-1-1 and immediately seek in-person medical assistance.

8. If there is a technological or equipment failure, I will contact the [Entity/Provider] by phone using the contact information below. If I have an emergency, I will contact 9-1-1 and immediately seek in-person medical assistance.

9. I understand that telehealth and telemedicine should not be used for emergency purposes, and that if an emergency exists, I should contact 9-1-1 and immediately seek in-person medical assistance.

10. I have a right to withdraw this consent to the use of telehealth and telemedicine at any time during the appointment.

11. I acknowledge that [Entity/Provider] has provided the identity, professional credentials (license number, title, specialty and board certifications), and the contact information of the health care provider who shall provide the telehealth and telemedicine services to me on behalf of [Entity/Provider]. I shall use the below information to contact [Entity/Provider] so I may reach that health care provider or a substitute health care provider authorized to act on behalf of [Entity/Provider]:

    [Contact Information]

12. I acknowledge that this consent form is for purposes of obtaining the above consent regarding telehealth and telemedicine. I understand that if additional testing or invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above consent regarding telehealth and telemedicine, and all of my questions have been answered to my satisfaction. The risks, benefits and any practical alternatives to using telehealth and telemedicine have been discussed with me in a language in which I understand. I have read and fully understand this form, and I represent that I am signing this consent voluntarily and intend to be legally bound by it.

PATIENT _____ DATE _____

PARENT OR LEGAL GUARDIAN _____ DATE _____

WITNESS _____ DATE _____