

## Informed Consent for Telehealth Services

Client Name: _____	
Date of Birth: _____	
Location of Client: _____	
Provider Name: _____	Location: _____
Consultant Name: _____	Location: _____
Consultant Name: _____	Location: _____

To better serve the needs of people in my community, health care services are now available by two way, interactive audio and video communications and/or by the electronic transmission of a variety of information including

- Patient medical records, histories, examinations and tests,
- Medical images including photographs, x-rays or other images
- Output data from medical devices and sound and video files

This information may assist in the evaluation, diagnosis, management and treatment of a number of health care problems. This means I can be evaluated by a distant health care provider or specialist over a two way television connection and/or by the electronic transmission of my health care information.

### **Possible Benefits:**

- Improved access to care
- More efficient medical evaluation and management
- Obtaining expertise of a distant specialist

### **Possible Risks:**

- Information transferred electronically may be more vulnerable to disclosure or tampering than information transferred by other means
- The electronic communication may fail to work or may be interrupted or become disconnected during the consultation
- The electronic connection may not be sufficient to provide the distant health care provider and the patient with information necessary to facilitate or make medical decisions.

### **By signing this form, I understand the following:**

1. Telehealth may involve electronic communication of my personal medical information to other health care providers who may be located in other areas, including out of state.
2. Other medical or non-medical personnel in addition to the consulting health care provider(s) may be present at the distant site and at my location, either on or off screen, during the transmission of my medical information or the two way television interaction as observers or technical assistants.

3. I will be informed prior to and during the session if personnel are present other than myself, individuals accompanying me and the distant health care provider(s). I have the right to ask unnecessary personnel at the distant site and at my location to leave the room during the telehealth interaction.
  
4. If I choose to access telehealth services from a commercial videoconferencing service, library, educational facility, or other non-health care facility, I understand that my medical information may be more vulnerable to disclosure or tampering since these facilities are not required to follow the laws that protect the privacy and confidentiality of health care information.
  
5. I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.
  
6. I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care or end the session at any time, without affecting my right to future care or treatment.

Understanding the above, I consent to the use of telehealth in the course of my health care.

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Signature of patient  
or legal guardian/representative

am/pm

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Witness

Date

Time (circle one)

I have personally explained the above information to the patient or their guardian/representative.

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Health Care Provider

am/pm

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Witness

Date

Time (circle one)