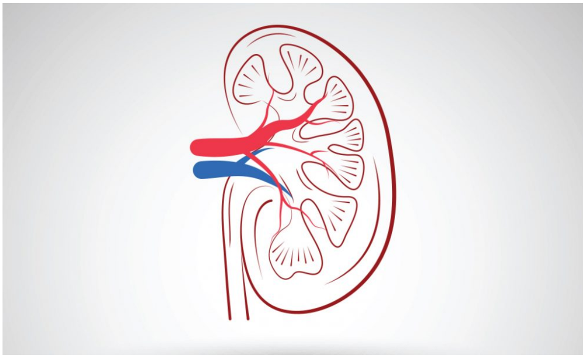

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CONSENT TO TELEHEALTH VISIT

Patient Name: ____
Date of Birth: ____
Location of Patient:____
Physician/Provider: ____

1. Purpose: The purpose of this form is to obtain your consent to participate in a telehealth visit in connection with the following service(s) and/or procedure(s):

2. Scope and Limitations: Telehealth visits are not appropriate for all medical services and procedures. Your Physician/Provider has the right to determine which telehealth service(s) and/or procedure(s) are appropriate for you.

3. Confidentiality and Security: All information given at your telehealth visit will be kept and protected in full compliance with federal and state privacy laws. Efforts, including (training of staff, use of a secured platform, updating/patching of software, and encryption of data, etc.) have been made to keep your information confidential. No system is flawless. You agree that technological failures may occur. Some or all of your information may be electronically lost or breached. The telehealth visit may also be interrupted or cancelled due to technical failure(s).

4. Medical Records: All federal and state laws about access to your medical records apply to telehealth. You may request access to your medical records.

5. Rights: You may opt out of the telehealth visit at any time. This will not change your right to future care or health benefits.

6. Risks and Consequences: You have been advised of the potential risks and benefits of telehealth visits. You have had a chance to ask questions about the telehealth visit. You have received satisfactory answers to your questions.

   By signing this form, you agree to the above terms and you agree that you understand the information in this form.

____ ______________________________
Signature of Patient or Patient's Representative | Date

____ ______________________________
Signature of Physician/Provider | Date