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CONSENT FOR TELEHEALTH CONSULTATION

PATIENT: ________________________________ Date of Birth: __________________________

I have been asked by my physician to take part in a telehealth consultation provided via a two-way audio/video link.

I understand that:

My physician and I will meet through a secure video-conference system.

1. I can ask that the exam and/or audio/video link be stopped at any time.
2. I understand that this procedure will be done through a two-way audio/video link. I know that it will be equal to a face-to-face visit with my health care provider.
3. I understand that there are possible risks with the use of this technology. These include, but are not limited to:
   a. Interruption or disconnection of the audio/video link
   b. A picture that is not clear enough to meet the needs of the consultation.
   c. The telehealth system is encrypted and meets HIPAA privacy standards, but there is a small chance that data security could be breached.

   If any of these risks occur, the procedure might need to be stopped.
4. I understand that this consultation will become part of my medical record kept by the healthcare provider. This consultation will not be recorded.
5. I understand that I must give my informed consent to participate in this consultation.

Signature of Patient: ____ Date: _________________

The above release is given on behalf of patient, because he/she is a minor or has been determined unable to give medical consent.

Signature of Parent or Legal Guardian: ___________________________________ Date: _________________

Relationship to Patient: _____________________________

Signature of Witness: ____ Date: _____________________