



---

Patient/Client Name

Date of Birth

I, \_\_\_\_\_, have been asked to receive health services via telemedicine. I understand that I will be receiving health care through interactive video conferencing equipment.

I understand that my participation in telemedicine is voluntary, and I may refuse to participate or decide to stop participation at any time, verbally or in writing. I understand that my refusal to participate or decision to stop participation will be documented in my medical record.

I understand that my privacy and confidentiality will be protected. When I am receiving services via telemedicine, I will be notified as to who is in the room (and/or) at the remote site.

I understand that the health care providers will have access to any relevant medical information about me, including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records.

I understand the healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

I understand that electronic communication cannot be used for emergencies or time-sensitive matters and should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand.

These risks include but are not limited to:

- It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

I have read this document, and I hereby consent to participate in receiving health services via telemedicine under the terms described above. I understand that this document will become a part of my medical record.

Please check the appropriate box below:

- I agree to participate in and receive health services via telemedicine.
- I choose NOT to participate in or receive health services via telemedicine.

This authorization, if not cancelled, will expire on (date) \_\_\_\_\_.

*Date is not to exceed 12 months, event, or condition upon which this authorization expires. If blank, authorization will expire 12 months from the date of signature below.*

---

Signature of Patient/Client/Authorized (legal) representative

Date

- I have received verbal consent from the Patient/Client above or Authorized (legal) Representative for telemedicine session(s).

---

Signature of Provider and/or Evaluator

Date

A copy of this authorization will be provided to the Patient/Client/Authorized Representative as requested.

CANCELLATION/REVOICATION:

---

Signature of Patient/Client/Authorized (legal) Representative

Date