ASPETUCK HEALTH DISTRICT
180 Bayberry Lane, Westport, CT 06880
Tel: (203) 227 9571 | Fax: (203) 221 7199 | https://aspetuckhd.org

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 participating 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 receive services via telemedicine, I will be notified of 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 the existing emergency 911services 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/REVOCATION:

_____

Signature of Patient/Client/Authorized (legal) Representative