TELEHEALTH INFORMED CONSENT AND AUTHORIZATION

Patient Name: ______________________________ Date of Birth: ______________________________

1. Purpose and Nature of Telehealth Services

I hereby consent to engage in telehealth services provided by my healthcare provider. Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share my health information for the purpose of diagnosis, consultation, treatment, education, care management, and self-management of my health care. I understand that telehealth may include video, audio, and/or other electronic communication.

2. Risks, Benefits, and Alternatives

I understand that telehealth has potential risks including but not limited to: information transmitted may not be sufficient for healthcare provider to make a diagnosis; delays in evaluation and treatment may occur; security protocols may fail resulting in a breach of privacy; and technical difficulties may occur during transmission. Benefits include improved access to healthcare services and convenience. Alternative to telehealth includes in-person visits.

3. Patient Rights and Responsibilities

I understand that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. I am responsible for providing accurate information and for informing the healthcare provider about any changes in my condition. I understand that I must be in a private and secure location during telehealth sessions to protect my privacy.

4. Confidentiality and Privacy

I understand that all existing laws regarding my privacy and confidentiality apply to telehealth services. However, because of the nature of electronic transmissions, there is a risk that my protected health information may be intercepted or accessed by unauthorized persons. The provider will take reasonable precautions to protect my information but cannot guarantee absolute security.

5. Recording Prohibition

I agree not to record any telehealth sessions unless expressly authorized in writing by my healthcare provider. Unauthorized recording may violate federal and state laws.

6. Consent for Use and Disclosure of Health Information

I authorize my healthcare provider to use and disclose my health information for purposes of providing telehealth services, billing, and as otherwise permitted or required by law. I understand that I can revoke this authorization at any time except to the extent that action has already been taken.

7. Emergency Situations

I understand that telehealth is not intended for use in emergency situations and that if I am experiencing an emergency, I

will seek immediate in-person care or call emergency services.

8. Technical Limitations

I acknowledge that telehealth services depend on technology and I may experience interruptions, delays, or other technical difficulties. My healthcare provider will not be liable for any failure or deficiency in the provision of telehealth services due to causes beyond control.

9. Voluntary Consent

I have read, or had read to me, the information provided above and have had the opportunity to ask questions which were answered to my satisfaction. I voluntarily consent to participate in telehealth services and understand that I may revoke this consent at any time.

PATIENT SIGNATURE	**HEALTHCARE PROVIDER SIGNATURE**
Signature: ___________________________	Signature: ___________________________

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