Telehealth Informed Consent Sample Template

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education.

Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient's Initials

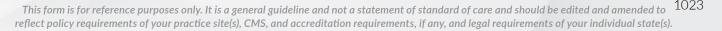
- I understand that telehealth involves the communication of my medical/mental health information in an electronic or technologyassisted format.
- I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.
- I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of ______ at the time of this service.
 - I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.
 - 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 agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care. I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records). I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me. I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit. I agree that I will be the only person in the room during my telehealth visit. I agree I cannot record my telethealth visits. I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm he or she is my healthcare provider. I understand that the social work practitioner will be discussing the treatment plan or protocol with 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.





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I understand that electronic communication may be use	ed to
communicate highly sensitive medical information, such	ı as
treatment for or information related to HIV/AIDS, sexual	ally
transmitted diseases, or addiction treatment (alcohol, di	rug
dependence, etc.).	

- I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.
- By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.
- I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
 - To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
 - I understand that electronic communication 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 certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between(Heta	ealthcare Provider's Name)	and staff and	(Patient's Name)
Patient or Legal Representative Signature	e/Date/Time	Relatio	nship to Patient
Print Patient or Legal Representative Nar	me	Witness Signat	cure/Date/Time
IEVLC	page 3		Assurance Service

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS, and accreditation requirements, if any, and legal requirements of your individual state(s).

I certify that I have explained the nature of this agreement to the patient/ patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Healthcare Provider Signature/Date/Time
_____ copy given to patient ______ original placed in chart

Optional National Emergency Crisis Language

I understand that due to the state of the current national emergency crisis, telehealth is offered by _______ to appropriate patients in an effort to comply with federal and state mandates of isolation and social distancing as an effort to provide protection to everyone.

The purpose of this form is to obtain your consent for a telehealth visit with one of our healthcare providers at the office of ______

The purpose of this visit is for the care of ______ during the national emergency.



