Informed Consent for Telehealth Services

I, the undersigned patient (or personal representative), acknowledge that I have read and fully understand this consent form. I agree to receive healthcare services from the provider listed below via telehealth.

Permitted Activities

I understand and consent to the use of telehealth services for the following activities, as determined to be appropriate by my practitioner:

- Diagnosis, evaluation, and treatment of my condition.
- Prescription refills.
- Appointment scheduling and management.
- Patient education and counseling.
- Consultation with other healthcare providers.
- Remote patient monitoring.

Practitioner's Role and Determination

I understand and agree that it is the role of the practitioner to determine whether or not my condition is appropriate for a telehealth encounter. I acknowledge that my practitioner may, at any time, determine that an in-person visit is necessary and may discontinue telehealth services.

Privacy, Security, and Risks

I understand that the laws protecting the privacy and confidentiality of my medical information apply to telehealth services. I have been informed of the following security measures to protect my information, as well as the potential risks to my privacy:

- **Security Measures:** All patient information transmitted during or in relation to telemedicine services is protected through transport-level encryption, such as Transport Layer Security (TLS) for email and HTTPS for web-based communications. Data on all workstations is encrypted at rest using whole disk encryption to render it unusable and unreadable to unauthorized individuals. These technical safeguards are part of a comprehensive security program designed to protect electronic Protected Health Information (ePHI) including the use of unique user IDs for system access, requiring multi-factor authentication, and conducting regular security risk assessments.
- **Potential Risks:** I acknowledge that despite these security measures, there are potential risks to my privacy, including but not limited to, the possibility of technical failures, data breaches, or unauthorized access during the telehealth session.

Hold Harmless Clause

I agree to hold my provider and their staff harmless for any information lost due to technical failures, including but not limited to, interruptions in video or audio connections, internet outages, or hardware malfunctions.

Third-Party Information Sharing

I understand that my patient-identifiable information will not be forwarded to a third party for any reason without my express, written consent, unless permitted under applicable law.

Patient Rights

I understand that I have the right to withhold or withdraw my consent to the use of telehealth services at any time, without affecting my right to future care or treatment. I also understand that I have the right to access my medical information and copies of my medical records.

Printed Name of Patient:

Signature: _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.