INFORMED CONSENT FOR TELEHEALTH

Patient Name: _____ Date of Birth: _____

To better serve the needs of our community, Swope Health may provide health care services through interactive video communications and the electronic transmission of information. This process is referred to as “telehealth” or “telemedicine.” This may assist in the evaluation, diagnosis, management, and treatment of some health care problems.

Before participating in telehealth services, please understand the following:

1. I understand I may be evaluated and treated by a health care provider or specialist who is at a different location than me. I understand this means the health care provider must rely on the information reported to make recommendations since we are not in the same room.
2. I understand that while Swope Health takes steps to ensure the communication is secure, there is a risk that security protocols could fail.
3. I will be informed if any additional Swope Health staff are to be present for the telehealth session. I understand all laws in place to protect my privacy and confidentiality still apply to telehealth services.
4. I understand there are additional potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
5. I understand that my health care provider or I can discontinue the telehealth session at any time.
6. I have had the alternatives to telehealth explained to me, and I understand that I can be seen in person at another time. I understand my participation in telehealth is completely voluntary.
7. I understand that while this telehealth session will not be recorded, it will be documented in my medical record. I further agree not to record any portion of the telehealth session.

_____ _____

Patient or Representative Signature Date