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CONSENT FOR TELEMEDICINE CONSULTATION

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.

2. I understand that the video conferencing technology that will be used will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

3. I understand there are potential risks to this technology, including interruptions and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that all confidentiality protections required by law or regulation will apply to my care:

- I will be informed of any other people who are present at either end of the telehealth encounter, and have the right to exclude anyone from either location.
- My healthcare provider will conduct telehealth visits in a confidential environment
- I have the right to refuse or stop participation in telehealth services at any time and request alternate services such as an in-person appointment. However, I understand that equivalent in-person services might not be available at the same location or time as telehealth services.
- If I do not want to receive health care services by telemedicine, it will not affect my right to future care or treatment.
- If an emergency occurs during a telehealth I should call 911 and stay on the video connection (if applicable) until help arrives.
- There will be no recordings or screen shots made of our visits.

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Signature Date