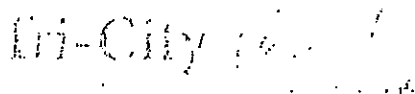

Informed Consent for Telehealth Services

Patient: ____ DOB:____________ SS#:__________________

Telehealth services allow my Provider to assess, diagnose, consult, treat, and educate using interactive audio, video, or data communication regarding my treatment. Telehealth uses electronic systems to incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and includes measures to safeguard the data and ensure its integrity against intentional or unintentional corruption.

I voluntarily consent to participate in Telehealth services for the purpose of receiving health services from Jeramiah Walker APRN-CNP and/or Tri-City Family Care.

I understand I have the following rights under this agreement:

- I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my information for face-to-face services. Any information disclosed by me during a Telehealth session is confidential.
- I understand I am responsible for placing myself in a private location during my services.
- I understand that the distribution of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without written consent from both Jeramiah Walker APRN-CNP and myself.
- I understand that there are risks unique and specific to Telehealth, including, but not limited to, the possibility that my Telehealth sessions or other communication with my Provider regarding my treatment could be disrupted or distorted by technical failures or could be interrupted.
- I understand the Provider will be at a different location from me.
- I have read and understand the information provided above. I understand I have the right to discuss any of this information with my Provider or their staff and to have any questions regarding my treatment answered to my satisfaction.
- I understand I can withdraw my consent to participate in Telehealth services by contacting Tri-City Family Care by telephone at 405-387-3838 or email at info@[illegible] or in writing to 100 N.W. 16th Street, Newcastle, OK 73065.
- I understand this form may be used for myself and anyone in my household whom I have parental rights/guardianship and who are listed below.

________________________________ DOB: ____________________ Date: ____________________
Patient Signature

________________________________ Date: ____________________
Provider

________________________________ Date: ____________________
Witness

Tri-City Family Care
100 NW 16th Street
Newcastle, OK 73065