INFORMED CONSENT FOR TELEHEALTH

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.

I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted 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 in the State of New York during all appointments.

I understand that all electronic medical communications carry some level of risk. These risks include but are not limited to:

1) Risks to confidentiality: electronic communication could be intercepted, forwarded, changed without knowledge
2) Issues in technology: technical challenges in the course of delivery of care
3) Crisis management/intervention: patients in a crisis requiring high levels of support and intervention may not have an option of in person evaluation with me. An emergency response plan would to be seen higher level services via EMS or 911 before engaging in telehealth.

I agree that information exchanged during my telehealth visit will be maintained by my doctor.

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 doximity, doxy, FaceTime 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 will verify 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 understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

I understand and agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, an EKG, urine test or drug screen or an in-office visit with my PCP.

I understand that my healthcare provider may choose to forward my information to an authorized third party with my written consent.

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.

I understand that the telehealth sessions shall not be recorded in any way by any party.

To the extent permitted by law, I agree to waive and release my healthcare provider practice from any claims I may have about the telehealth visit.

I understand that electronic communication should never be used for urgent situations. Emergency communications should be made to EMS/911 services in the community.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care.

I hereby consent to the use of telehealth for psychiatric care. By signing below, I certify that I am the patient's legal representative or that I am the patient and am 18 years of age or older. I have carefully read and understand the above statements. I have had all my questions answered.

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(Patient Signature/Patient's parent or legal guardian) (Date)