SUNSHINE BEHAVIORAL HEALTH CENTER, LLC

TELEMEDICINE RECIPIENT CONSENT FORM

I (name) _____ agree to receive this health care service, (type of service) _____, as a telemedicine service. I understand that the health care practitioner (name) _____ is located in another location (facility name and address) _____. A telemedicine service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for twelve months for follow-up telemedicine services with the health care provider, medical treatment, provider payment, and health care operations. The original document is retained in the medical record, and the recipient receives a copy.

I also understand that:

- I can decline the telemedicine service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the telemedicine service.
- If I decline the telemedicine services, the other options/alternatives available for me, including in person services, are as follows:

_____

_____

- The same confidentiality protections that apply to my other medical care also apply to the telemedicine service.
- I will have access to all medical information resulting from the telemedicine service as provided by law.
- The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my **additional** written consent.
- I will be informed of all people who will be present at all sites during my telemedicine service.
- I may exclude anyone from any site during my telehealth service.
- I may see an appropriately trained staff person or employee in-person immedicately after the telemedicine service if an urgent need arises **OR** I will be told ahead of time that this is not available.
- I may contact the healthcare provider at phone number _____ for any questions I have related to medical services received through a telemedicine provider/site.

I have read this document carefully, and my questions have been answered to my satisfaction.

Signature of Recipient _____

Date_____

OR

Signature of Parent or Legal Representative _____

Date_____

Telemedicine Consent:

Signature of Person Obtaining Consent_____

Date_____

Facility Name_____

Facility Address_____