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Informed Consent for Telehealth Services

Patient Name: _______________________________ **Date of Birth:**____________________	**Location of Patient:** ______________________________	**Medical Record#:** _____________
Physician Name: Moline Blanc, PA **Location: Ormond Beach, FL**		**Date Content Discussed:** ________________

Introduction

Telehealth is the provision of healthcare remotely by means of telecommunications technology. It involves the use of electronic communications and applications to enable health care providers to provide health and wellness services for the purpose of increasing access to care. The information may be used for diagnosis, individualized treatment plan, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to health and wellness services by enabling a patient to remain at a remote site while the medical provider conducts health and wellness visits at distant/other sites.
- More efficient evaluation and treatment planning.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any health service, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for treatment and diagnosis by the provider;
- Delays in service delivery could occur due to deficiencies or failures of the equipment. In the event of disruption to service contact Shekinah Health & Wellness Center at (386) 206-2929;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods may be available to me, and that I may choose one or more of these at any time.

5. I understand that telehealth may involve electronic communication of my personal medical information to the medical provider.

6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand the site utilized for Telehealth services is Doxy.me. There is an assigned link for Shekinah Health & Wellness Center: **https://doxy.me/shekinah**. In the event there is technology failure, I understand that any use of platforms outside of the aforementioned are NOT HIPAA compliant thereby putting my protected information at risk of being breeched.

Patient Consent For The Use of Telehealth
I have read and understand the information provided above regarding Telehealth, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care.

I hereby authorize Shekinah Health & Wellness Center to use Telehealth in the course of my diagnosis and treatment.

____
Signature of Patient (or person authorized to sign for patient)
*If authorized signer, relationship to patient:*____________

Witness: ____

I have been offered a copy of this consent form (patient’s initials) _______

Date:_____________