Community Health Center of the North Country

**TELEMED**

Health Center

# Informed Consent for Telehealth Consultations

**Patient Name: _____ Date of Birth: _____**

**Referring Provider Name: _____ Date Discussed: _____**

**Consultant Name: _____ Specialty: _____**

To better serve the needs of CHCNC patients, services are available by interactive video communications and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management and treatment of a number of healthcare diagnoses. This process is referred to as "telemedicine" or "telehealth". This means that you may be evaluated and treated by a healthcare provider or specialist from a distant location. Since this may be different than the type of consultation which you are familiar, it is important that you understand and agree to the following statements.

***I understand that:***

1. **I can withdraw consent for telehealth services at any point during the process. Further, I understand that refusal to participate in the telehealth program will not affect the right to future care or treatment.**
2. **My healthcare provider, CHCNC, has recommended for me to engage in services via telemedicine.**
3. **My healthcare provider has explained to me how the telemedicine technology will be used to affect such an encounter.**
4. **There are potential risks to this technology, including interruptions and technical difficulties. I understand that my healthcare provider and/or a representative of my healthcare provider, or I, can discontinue the telemedicine encounter if it is felt that the interpretations and/or technical difficulties are affecting the quality of the encounter.**
5. **I will be informed of any additional personnel that are to be present other than myself, individuals accompanying me, my healthcare provider or a representative of my healthcare provider via video, and give my verbal permission prior to entry of any additional personnel.**
6. **My healthcare provider for whom the on-site examination or treatment is performed will keep a record of the encounter in my medical record.**

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7. **I voluntarily consent to healthcare services provided by my healthcare provider or a designee, which may include diagnostic tests, medication, examination and treatment considered necessary to treat my health problem.**
8. **I may access my medical records, including those generated via a telehealth visit, in accordance with the Health Insurance Privacy and Portability Act requirements, as well as any other federal, state, and local regulations.**
9. **I authorize payment directly to CHCNC for all benefits payable by my insurance carrier.**
10. **While I may benefit from telehealth services, results are not guaranteed or assured.**

I have read and understand the information provided above regarding telemedicine, have discussed it with my medical/dental provider or their assistants as designated, and any questions that I had have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical/dental care.

_____ _____

Patient Signature Date

_____ _____

Referring Provider Signature Date

**I have been offered a copy of this consent form for my records: _____ (patient initials)**