**Practice Name**

**Practice Address**

**CONSENT FOR TELEHEALTH SERVICES**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ MRN: \_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Telephone No.: \_\_\_\_\_\_\_\_\_\_\_

Physician’s Name & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ABOUT TELEHEALTH**

Telehealth (also called telemedicine) is a means to receive and deliver health care services through electronic communication when the patient and health care provider are at different locations. Telehealth aims to improve access to health care services. Telehealth involves audio, video, and/or other electronic communication to allow you to consult with your health care provider and/or review your health care information for the purpose(s) of diagnosis, treatment, follow-up, and/or other medical advice.

Telehealth improves access to health care services, eliminates transportation concerns, and increases comfort. However, telehealth may not be as complete and effective as in-person health care services due to limitations of a physical exam and observations by the health care provider, limited access to technology, and other technical difficulties.

During your telehealth session, your medical history and personal health information may be discussed with other health care providers and personnel. While precautions are taken to secure the confidentiality of your telehealth session and personal health information, the electronic transmission of medical information can be incomplete, lost, or otherwise disrupted by technical failures. Despite such measures, there is the possibility of electronic transmission and storage of medical information being accessed by unauthorized persons and potentially causing a breach of your privacy. The risks of a privacy violation increase if you use a shared device, are on a shared network, or use an unsecure connection.

California law requires the patient be physically located in California at the time telehealth services are rendered. In some circumstances, a patient who is a resident of California may receive telehealth services if the patient is temporarily located out-of-state.

**INFORMED CONSENT TO USE TELEHEALTH**

By signing this Consent, I acknowledge I have read the above information and understand and agree to the following:

1. Telehealth is voluntary. I have the right to withdraw consent at any time. I have the right to request in-person care with my health care provider.
2. I will assist my health care provider in completing an assessment regarding the suitability of using telehealth services, including verifying of my full name, disclosing my physical location, confirming I have privacy and appropriate communication, and my consent to proceed with telehealth.
3. My health care provider is located in California and licensed by the State of California. If I am not located in California, I acknowledge my health care provider may not be able to prescribe medication and/or assist me in an emergency situation. In the event of an emergency, I understand I should call 911 or proceed to the nearest emergency department for assistance.
4. There are limitations and risks to receiving telehealth services as compared to an in-person visit and specific results cannot be guaranteed or expected. My health care provider may discontinue telehealth services and require in-person care if my health care provider deems such to be appropriate.
5. The telehealth appointment will not be recorded via audio or video recording without my written consent. If I agree in writing to have my telehealth appointment recorded via audio or video recording, I understand the recording and/or transcript will become a part of my medical record.
6. I have the right to access my medical information and obtain my medical records in accordance with California law.
7. Telehealth services will be billed to my health insurer, if any, and I will be billed for any patient responsibility pursuant to my health insurance plan.
8. I submit to the exclusive jurisdiction of the Superior Court of California and agree any claim, lawsuit, or other legal proceeding arising out of or relating to telehealth services provided by my health care provider and/or my health care provider’s staff will be brought solely and exclusively in the Superior Court of California. I also agree the interpretation of this Consent will be exclusively governed by and construed in accordance with the laws of the State of California.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the information above and have had the opportunity to discuss any questions and concerns with my health care provider. All of my questions and concerns were addressed to my satisfaction, and I consent to telehealth services with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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Date Patient’s Signature