



## Consent for Telehealth Services

1. \_\_\_\_\_ I understand that the laws that protect privacy and the confidentiality of medical 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 during a telehealth interaction and may receive copies of this information for a reasonable fee.
4. \_\_\_\_\_ I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. \_\_\_\_\_ I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be in other areas, including out of state.
6. \_\_\_\_\_ I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. \_\_\_\_\_ 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.

### **Patient consent to the use of telehealth**

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

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



**M.Chávez** MD, SC  
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