

**Telehealth Consent Form**

***Definition***: Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: · Patient medical records · Medical images · Live two-way audio and video · Output data from medical devices as well as sound and video files. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data, but will also include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

By signing this form, I understand the following:

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 the course of a telehealth interaction, and may receive copies of this information.

4. I understand that my insurance company may or may not cover telehealth services, but I can also opt to pay as a private pay case and still have the service available to me.

5. 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 therapist as it may be designated.

I hereby give my informed consent for the use of telehealth visits in my treatment plan. I hereby authorize Physical Therapy Center to use telehealth visits in the course of my diagnosis and treatment.

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Signature of Patient (or person authorized to sign for patient) Date

If authorized signer, relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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