

HIPAA* AUTHORIZATION FORM

Informed consent to participate in a telemedicine visit

To better serve the needs of patients, health care services are now available by interactive video communications, audio communications, and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management, and/or treatment of a number of health problems. This process is referred to as “telemedicine” or “telehealth.” This means that your health problems may be evaluated, diagnosed, managed, and/or treated by a health care provider or a specialist (“Healthcare Provider”) from a distant location. Since this may be different than the type of consultation with which you are familiar, it is important that you understand and give **your informed consent to the use of telemedicine in your care.**

DISCLAIMER. TELEMEDICINE IS NOT APPROPRIATE FOR A MEDICAL OR MENTAL/BEHAVIORAL HEALTH EMERGENCY. FOR A MEDICAL EMERGENCY, DIAL 911 FOR ASSISTANCE. FOR A MENTAL/BEHAVIORAL HEALTH EMERGENCY, YOU CAN: (I) CALL 911; (II) GO TO THE NEAREST EMERGENCY ROOM; OR (III) CONTACT YOUR LOCAL CRISIS CENTER.

TELEMEDICINE. Telemedicine involves the use of electronic communications to enable Healthcare Providers at different locations to (i) evaluate, diagnose, manage, and/or treat health problems ranging from common ailments to mental/behavioral health issues and (ii) share individual patient medical information for the purpose of improving patient care. For purposes herein, Healthcare Providers may include *physicians, psychiatrists, nurse practitioners, physician assistants, licensed professional counselors, and social workers, all of which may also be referred to as clinicians.* The information may be used for evaluation, diagnosis, management, and/or treatment (including therapy), as well as follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way video and/or audio
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software **security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data** and to **ensure its integrity against intentional or unintentional corruption.** Responsibility for patient care should remain with the patient’s primary care physician or other local clinician, if the patient has one, as does the patient’s full medical record.

POSSIBLE RISKS. As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, the Healthcare Provider may determine that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled video consult.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors

By checking the box indicating that you agree to the terms of this HIPAA Authorization Form, you acknowledge that you have read, understand, and agree with the foregoing as well as the following:

- I understand that the laws that protect privacy and the confidentiality of medical/mental/behavioral health information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent. However, information may be released without my consent in cases of medical/mental/behavioral health emergency, abuse, neglect, court order, insurance billing claims requirements, adult and program evaluation, and where otherwise legally required.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- I understand the alternatives to telemedicine consultation as they have been explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the consulting Healthcare Provider.
- I understand that telemedicine may involve electronic communication of my personal medical/mental/behavioral health information to other medical practitioners who may be located in other areas, including out of state. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. I understand that I must call 911 or go to the nearest emergency room if I am experiencing a serious side effect to a medication that is of immediate danger to my health.
- I understand that my health care information may be shared with other individuals for scheduling and billing purposes. The above mentioned people will maintain the confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (i) omit specific details of my medical history/physical examination that are personally sensitive to me; (ii) ask non-medical personnel to leave the telemedicine examination room; and/or (iii) terminate the consultation at any time.

ELECTRONIC SIGNATURE. I have read this HIPAA Authorization Form (including, but not limited to, the risks and benefits associated with teleconferencing by video, audio, or other electronic means) and I understand it. All of my questions have been answered to my satisfaction and **I hereby give my informed consent to participate in a telemedicine visit under the terms described herein.**

I understand and acknowledge that my ability to access the Viclinic Service is conditional upon the above-mentioned criteria of my informed consent, and that Viclinic 's Healthcare Providers are relying upon this informed consent in order to interact with and facilitate health care services to me.

*HIPAA -The Health Insurance Portability and Accountability Act- is a law that works to protect the medical information of U.S. citizens.