

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in telehealth consultations.
2. I have been explained how the video conferencing technology will be used and understand that such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
5. I understand that my healthcare provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connection is not adequate for the situation.
6. I understand the potential risks associated with telehealth consultations.
7. I have had a direct conversation with my provider, during which I had the opportunity to ask questions about telehealth consultations. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me.

Acknowledgement of Receipt of Consent for Telehealth Consultation

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of telehealth.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature: _____

Print Name: _____

Date: _____