TriHealth Informed Consent for Telehealth

Patient Name: _____ **Date of Birth:** _____ **Sex:** _____

Patient MRN: _____

Address: _____
Street

_____
Street Line 2

_____
City, State Zip Code

Primary Phone Number: _____

Secondary Phone Number: _____

I understand that part or all of my care may be provided through telehealth, which allows providers at different locations to examine me and devise a treatment plan through electronic or other means of communication. I understand the benefits of telehealth include, but are not limited to, easier and quicker access to providers, even at a distance. As with any medical treatment, telehealth has some risks. I understand that the risks of telehealth include, but are not limited to, insufficiency or delays in information capable of being transmitted and, therefore, inability to properly or timely treat a condition. In rare instances, security breaches could take place, causing a breach of privacy. I understand TriHealth has technical protocols in place to protect my privacy, Finally, I understand that being treated by a practitioner who may have incomplete access to my complete medical history could result in adverse drug reactions or interactions or other judgment errors. I understand that these are not all of the risks, but just some of the material risks. I acknowledge and agree that no guarantee or assurances have been made to me concerning the results of telehealth. I have been informed of the alternatives to telehealth and consent to proceed with a telehealth consultation.

I understand that other individuals may be present to assist with the telehealth encounter. I will be informed of the identity of all parties who are present at the distant and local site, and I understand I have the right to exclude anyone from either site or terminate the visit at any time.

I understand that my provider or I may discontinue the telehealth visit at any time, for any reason, including if it is felt that the connection is not adequate for the situation. Withdrawing my consent to the use of telehealth will not affect my right to future care or treatment. I have had all of my questions answered to my satisfaction, and consent to participate in a telehealth consultation.

Signature of Patient (if 18 years old or older) or Legal Guardian if Patient is a minor Date

Printed name of Legal Guardian/Representative (only if applicable)

Signature of Witness Date