Print Name: _____ City: _____

Date of Birth: _____ Last 4 Digits of SSN: _____ State: _____

Address: _____ Zip: _____

Site Location: _____ MRN: _____

Introduction

The purpose of this document is to obtain consent for Telehealth Services with the University of Miami Health System. Telehealth service is the delivery of healthcare services when the healthcare provider and patient are not in the same physical location/site through the use of various technology. Information provided may be used for diagnosis, therapy, follow-up and/or education, and may include any combination of the following: (1) patient medical records; (2) medical images; (3) live two-way audio and video; (4) interactive audio; and (5) 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.

Primary responsibility for your medical care should remain with your local primary care doctor, if you have one, as does your medical record.

Since this may be different than the type of consultation with which you are familiar, it is important that you understand, acknowledge and agree to the following statements:

- I understand that I have undertaken to engage in a telehealth encounter that will contain my personal identifying information as well as protected health information.
- I understand that the consulting healthcare provider will be at a different location from me. A healthcare professional ("presenting practitioner") may be present with me in the room to assist in the consultation.
- I voluntarily consent to healthcare services provided which may include review of diagnostic tests, medications, examinations, and consultation on pre- or post- medical or surgical treatments considered necessary for treatment.
- I will be informed and given the opportunity to verbally consent before additional persons at either the patient or provider site are to be present.
- **RELEASE OF INFORMATION:** UHealth staff and/or healthcare providers who provide professional services to me are authorized to provide medical information from my medical record to the referring physician, if any, and to any insurance company or third party payer for the purpose of obtaining payment of the account. UHealth is authorized to release information from my medical record to any other health care facility or provider to which my care may be transferred.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth services at any time in the course of my care, without affecting my right to future care or treatment.
- I have been informed of and accept the potential risks associated with telehealth, such as failure of security protocols that may cause a breach of privacy of personal and/or medical information.

- 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 or as may be allowed by law.

- I understand that using a form of communication technology other than UHealth approved telehealth applications may compromise security protocols or cause information transmitted to be insufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the consulting healthcare provider. I understand that such communications may not be included as part of my chart or my medical record.

- I understand that no audio or video recordings of the telehealth encounter will be made or stored by the University. The consulting healthcare provider will take progress notes of the telehealth encounter which will be maintained in the University's electronic medical records system. I have the right to inspect all information obtained and maintained in my medical records during the course of a telehealth encounter, and may receive copies of this information for a reasonable fee.

- I have been given the opportunity to ask the University of Miami questions relative to my Telehealth encounter, security practices, technical specifications, and other related risks

By signing this form, I certify:

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

Signature of Patient or Personal Representative _____ Date _____

Printed Name of Patient or Personal Representative _____

If Personal Representative, authority to act on behalf of Patient and Relationship to Patient _____

Signature of Witness _____ Date _____

Relationship to Patient _____