Community Health Centers, Inc.
(407) 905-8827 (352) 314-7400
WWW.CHCFL.ORG
Fax: (321) 221-2048

Telemedicine Consent Form

Introduction

Telemedicine is the delivery of health services when the healthcare provider (Community Health Centers, Inc.) and you are not in the same physical location and the services are provided through the use of technology. In the provision of Telemedicine services electronically-transmitted information may be used for diagnosis, therapy, follow-up and/or patient education, and may include any of the following:

- Patient medical records
- Medical images
- Interactive audio, video, and/or data communications
- Output data from medical devices and sound and video files

The interactive electronic system used by Community Health Centers, Inc. will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. However, you must also use their best efforts to protect and secure you health information. For example:

- Your Telemedicine appointment should be in a private location;
- You should turn off any nearby electronic devices that may overhear or record information;
- You should use your own personal computer or mobile devices as opposed to using a workplace device or device in a public space;
- You should make your security on your computer or mobile device is up to date;
- You should use strong, unique passwords for your computer or mobile device;
- You should use the lock screen function on any devices;
- You should delete health information on your computer or mobile device if it is no longer needed;
- You should use multi-factor authentication and encryption tools if available;
- You should use avoid using public wi-fi networks and USB ports at public charging stations;
- If you are suspicious about a link or have any doubts let your Community Health Centers, Inc. provider know.

Potential Benefit

1. Improved access to convenient medical care by enabling you to remain at a remote location while Community Health Centers, Inc. obtains test results and consults with healthcare practitioners at distant/other sites.
2. Obtaining the expertise of a distant specialist.
3. You may not need to travel to the consult location.
4. You may have access to a specialist through this consultation.

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Potential Risk

1. The video connection may not work or that it may stop working during the consultation.
2. The video picture or information transmitted may not be clear enough to be useful for the consultation.
3. You may be required to go to the location of a consulting physician if it is felt that the information obtained via Telemedicine was not sufficient to make a proper evaluation.
4. If you fail to adhere to standard secure recommendations (see above) your health information could be at risk.

I Understand

The laws that protect the privacy and confidentiality of medical information also apply to Telemedicine.

- I can decline Telemedicine services at any time without affecting my right to future care, treatment, and/or programs.
- I may have to travel to a health care professional in person if I decline the Telemedicine service.
- I will have access to all medical information resulting from the Telemedicine service as provided by law.
- I will be informed of all personnel present at my Telemedicine service; other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.
- I may receive a limited physical examination that will take place during the videoconference and that I have the right to ask my healthcare provider to discontinue the conference at any time.
- That certain remote communications technology is not fully secure.

Consent

I have read and understand the information provided above regarding Telemedicine and all of my questions and concerns have been addressed to my satisfaction. I hereby give my informed consent for the use of Telemedicine in my medical care.

I hereby consent to and authorize Community Health Centers, Inc., to use Telemedicine in the course of my medical care.

Print Name of Consenting Person | Signature of Consenting Person | Date

Patient Name | Patient Date of Birth

Relationship to Patient is:

☐ Patient ☐ Parent ☐ Legal Guardian ☐ Authorized Person