HCG OF JAX CONSENT TO TELEHEALTH VISIT

Patient Name: ____

1. Purpose:

The purpose of this form is to get your consent for a telehealth visit.

2. How Telehealth Works:

In a telehealth visit, you will interact in real time with your healthcare provider ("Provider") via the use of secure electronic or telephonic communication.

3. Pros and Risks of Telehealth:

With telehealth, you will have the convenience of being able to remain in your home while the provider consults with you from a different site, thus enabling there to be no interruption in your patient care while you are unable to come to the office in-person. However, there are rare events in which the provider may determine that the transmitted information is of inadequate equality, thus necessitating a rescheduled telehealth consult. Also, very rarely, security protocols could fail, causing a breach of privacy of personal medical information.

4. Medical Record and Privacy:

All federal and state laws covering access to your medical records (and copies of medical records) also apply to telehealth. All information given at your telehealth visit will be protected by federal and state privacy laws.

5. Your Rights:

You may opt-out of the telehealth visits at any time. This will not change your right to future care or health benefits.

6. Waiver/Release:

By signing below, you consent to receive services via telehealth and understand and agree the you solely assume the risk of any errors or deficiencies in the electronic transmission of information during your telehealth visit.

Signature of Patient: ____

Name: ____

OR

Signature of Patient's Representative: ____

Name: ____