

VISTA EAP AND COUNSELING AND INTENTIONS YOGA

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TELEHEALTH CONSENT

Telehealth involves the use of electronic communications to enable providers at different locations to share individual client information for the purpose of improving client care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow up and/or education, and may include any of the following. ~ Client health record ~ Live two-way audio and video ~ Output data from health devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits: ~ Improved access to care by enabling a client to remain in their provider's office (or a remote site) while the providers obtains test results and consults from practitioners at distant/other sites ~ More efficient client evaluation and management ~ Obtaining expertise of a distant specialist

Possible Risks: ~ In rare cases, information transmitted may not be sufficient (poor resolution of images) to allow or appropriate decision making by the providers and consultants ~ Delays in evaluation and treatment could occur due to deficiencies or failures of equipment ~ In rare cases, a lack of access to complete health records may result interactions or judgment errors ~ In very rare cases, security protocols could fail, causing a breach of privacy or personal health information.

By Signing this form, I understand the following: 1) The laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to any other entities without my consent. 2) I have the right to withhold or withdraw my consent to the use of telehealth at any time without affecting my right to future care of treatment. 3) I have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may receive copies of this information for a reasonable fee. 4) A variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction. 5) Telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state. 6) It is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers. 7) I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Client Consent to the use of Telehealth

I _____ have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent fo the use of telehealth in my care.

Signature of Client

_____ Date _____

Witness _____ Date _____