TELEHEALTH PATIENT CONSENT/REFUSAL FORM

Patient Name: _____ Date of Birth: _____

Cell Phone: _____ Email: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in telehealth consultation for outpatient evaluation and management of acute and chronic health conditions. Telehealth allows you to communicate with your physician about your health and medical conditions to determine a treatment plan.
   a. Electronic systems will incorporate 128-bit HIPAA 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 against corruption. During a "national emergency" authorization may be granted to use a less secure platform. You will be notified if this occurs.
   b. The patient and/or guardian will not hold the physician liable for any clinical information that is lost due to technical failures.
2. BENEFITS: Improved access to medical care by allowing patients to receive medical care from outside a healthcare facility.
3. RISKS: As with any medical care there are potential risks associated with the use of telemedicine: information transmitted may not be sufficient to allow for appropriate decision making, delays could occur due to deficiencies or failure of the equipment, in rare cases security protocols could fail causing loss of privacy of personal medical information. Your provider may advise that an in-person visit is necessary.
4. NATURE OF TELEHEALTH CONSULT/VISIT: During the telehealth consultation:
   a. The visit will take place through interactive real-time audio and video communication. You will have the opportunity to ask questions and discuss your health concerns with your provider.
   b. Details of your current health concerns and medical history will be discussed.
   c. A physical examination of you may take place.
   d. Photos may be taken during the visit and will be loaded directly into the medical record. This will only be done with your verbal consent (picture of a rash, which can be used to consult with other providers).
5. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to telehealth visits. Sharing of any patient-identifiable images or information for this telehealth visit to researchers or other entities shall not occur without your consent.
6. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and South Carolina state law apply to information disclosed during telehealth visits.
7. RIGHTS: You may withhold or withdraw consent to telehealth care at any time without affecting your right to future care or treatment.
8. PRESCRIBING: The physician will prescribe medications that are appropriate for the symptoms and on diagnosis made during the telehealth visits. Prescriptions will be sent electronically through the electronic medical record to the patient's pharmacy. Prescription of controlled substances from schedule II through IV will not be prescribed through telehealth visits.
9. EMERGENCY EVENT: If a medical emergency occurs during the telehealth visit, your physician will take necessary steps to secure appropriate and timely care for the patient. If the patient is incapacitated, the physician will call 911 emergency services and remain on the line until care has been transferred. If a family member is available, the physician will guide them through contacting 911 emergency services. The patient and/or guardian agrees that the telehealth physician, nor Charleston Allergy & Asthma, will be held liable for any cost incurred for emergency services care that was activated on the best judgement of the physician with the available information.

10. AFTER HOURS CARE: Patients who have an established care relationship with a Charleston Allergy & Asthma physician may access non-emergent care after normal business hours by contacting the main office number.
11. RISKS, CONSEQUENCES & BENEFITS: You have been advised of the potential risks, consequences and benefits of telehealth. Your provider has discussed this and you have had an opportunity to ask questions about this information. All your questions have been answered and you understand the written word above.

I **AGREE or DISAGREE** (CIRCLE ONE) to participate in telehealth visits as discussed above:

Signature: _____

If signed by someone other than the patient, indicate relationship: _____.

DATE: _____ TIME: _____

WITNESS: _____

COUNSELING PHYSICIAN: _____