

TELEHEALTH CONSENT

CONSENT. I hereby consent to the use of telehealth by my Quality Rehab Physical Therapy provider. I understand that telehealth involves the communication of my health information, both orally and visually, with providers involved in my care who are located in a different location.

RISKS, BENEFITS AND ALTERNATIVES. I understand that I can expect benefits from telehealth, but no particular result can be guaranteed. The benefits of telehealth include having access to your provider without having to travel to the clinic or reduce occurrences. A potential risk of telehealth is that because of my specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telehealth appointment.

In the event that my telehealth session is interrupted, due to technical difficulties, the provider will attempt to contact me via phone. The evaluation of appropriateness of continuing with telehealth sessions will continue throughout my treatment including monitoring of symptoms and cooperativeness in assuming the responsibilities inherent in remote care. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to a telehealth session is a face-to-face visit with my provider.

MEDICAL INFORMATION AND RECORDS. All laws concerning patient access to medical records and copies of medical records apply to telehealth. Dissemination of any patient identifiable images or information from the session to researchers or other entities shall not occur without my consent.

CONFIDENTIALITY. All existing confidentiality protections under federal and Colorado law apply to information used or disclosed during your telehealth session.

PATIENT CHOICE. I have the right to withhold or withdraw consent to a telehealth session at any time before and/or during the session without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

I have read the consent form and understand the Risks, Benefits and Alternatives, that my medical records will be maintained the same as if i were being see in the clinic, that my telehealth session is confidential, and that i have the right to discontinue telehealth sessions without affecting my right to care at Quality Rehab Physical Therapy. *

Patient Signature: _____ **Date:** _____