Cherry Health
Comprehensive. Quality. *Healthcare.*

Telehealth Informed Consent

Patient name:	Date of birth:

As a patient receiving services through telehealth technologies, I understand:

Introduction of Telehealth:

- Telehealth is the delivery of services using interactive technologies (including but not limited to video, phone, text, apps and email) between my provider and me who are not in the same physical location. This service may not involve direct face to face communication.
- These services rely on technology, which allows for greater convenience in service delivery.

Health Information Protection:

- The technologies used in telehealth include network and software security measures to protect the privacy of my information communicated via any electronic network. This includes measures to protect my health record information and to help in protecting against intentional or unintentional misuse.
- All services are documented in my health record.

Exchange of Information:

- The exchange of information will not be direct and any paperwork exchange will be provided through electronic means or through the mail.
- During my telehealth service, details of my medical history and personal health information may be discussed with myself and other providers through the use of interactive video, audio or other telecommunications technology.

Technology Requirements:

- I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.

Risks of Technology:

- Cherry Health makes every reasonable effort to safeguard and protect my confidential health information.
- These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
- The software used is Health Insurance Portability and Accountability Act (HIPAA) compliant.

Local Providers:

- If a need for direct, face to face services occurs, it is my responsibility to contact providers in my area such as:

_____

_____

or to contact my health center for a face to face appointment. I understand an appointment may not be immediately available.

Declining Telehealth:

- I may decline any telehealth services at any time without jeopardizing my access to future care, services, and benefits.

Emergency Plan:

- In emergency situations:

_____

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Disruption of Service:

- Should service be disrupted:

  _____

  _____

- For other communication:

  _____

  _____

Patient Communication:

- It is my responsibility to maintain privacy on my end of communication. Insurance companies, those authorized by me, and those permitted by law may also have access to records or communications.

Group Expectations:

- You must use a secure (non-public) internet connection to participate in group.
- In order to maintain the group's privacy, it is important to connect from a quiet and private room with no interruptions or distractions from people or other devices. It is imperative that no persons other than yourself are in hearing or visual proximity to you during the meeting.
- Use of headphones and screen privacy is maintained to protect what is being shared and the identity of other group members.
- Should someone enter your room, alert your group, immediately cover your screen, and reduce volume to 0. If the disruption is not brief, you may need to exit the group until you are alone again.
- Under no circumstances are you to record any visual or auditory part of the group session.
- Although guarantees cannot be provided by the group facilitator(s), group members must agree to maintain the confidentiality of other group members. This means that you may not disclose names or other identifying information about group members, nor may you discuss the personal issues and experiences of other members. This includes but is not limited to written posts and pictures on social media forums. If a violation occurs you will be legally liable for the breach of confidentiality.

Consent

I certify that I read or understand and write in English. I have read or another person has read to me the above consent. I fully understand the above consent written in English. I have had my questions answered. All blanks were filled in before I signed the consent.

Patient/Parent/Legal Guardian Signature:	Date:
Provider Signature:	Date:
Witness Signature:	Date: