



## Telehealth Member Consent Form

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

GA MED ID#: \_\_\_\_\_

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with the following procedure(s) and/or service(s):

\_\_\_\_\_  
\_\_\_\_\_

2. **NATURE OF TELEHEALTH CONSULT:** During the telehealth consultation:

- a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
- b. A physical examination of you may take place.
- c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
- d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

4. **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 Georgia state law apply to information disclosed during this telehealth consultation.

5. **RIGHTS:** You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. **DISPUTES:** You agree that any dispute arising from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

7. **RISKS, CONSEQUENCES & BENEFITS:** You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by someone other than the patient, indicate relationship: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_