CONSENT FOR USE OF TELEHEALTH SERVICES

Overview of Telehealth

Telehealth is a way to visit healthcare providers involving the use of electronic communications. You can talk to your provider from any place, including your home, without going to a clinic or hospital. Providers may include urgent care practitioners, primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include live two-way audio and video and other materials (e.g. medical records, data from medical devices). By signing below, you consent to engaging in telehealth with your provider.

Attestation

1. OUR PROVIDERS DO ***NOT*** ADDRESS MEDICAL EMERGENCIES. If you believe you are experiencing a medical emergency, you should **dial 911** and/or go to the nearest emergency room. Please do not attempt to contact APNS after receiving emergency healthcare treatment, you should visit your local primary care provider in person.
2. You have the right to withhold or withdraw consent at any time without affecting your right to future care or treatment.
3. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, you understand that the information disclosed by me during the session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim or yourself; and where you make my mental or emotional state an issue in a legal proceeding.
4. You understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without your written consent.
5. You understand that your healthcare information may be shared with other individuals for treatment and healthcare operations purposes.
6. You understand that telehealth is limited modality for healthcare assessment, diagnosis, and treatment. It is not and should not be used a replacement for in person medical care and an established relationship with an in person primary care provider. Telehealth is only intended to function as a supportive measure for certain and specific healthcare needs. You are strongly encouraged to establish and maintain with regular follow up in person visit with a primary care provider for comprehensive and long term health management. APNS does not replace an in person long term established primary care provider relationship for comprehensive health management.
7. You understand that there are risks, limitations, and consequences from the

use of telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider that:

a. Certain medical assessments may be missed due to the virtual limitations inherent in a telehealth visit and you recognize that it is not the fault of the provider and you do no hold the provider or APNS liable for missing potentially morbid or mortal diagnoses as a result of using a limited medical forum.
b. The transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your medical information could be interrupted by unauthorized persons; and/or the electronic storage of your medical information could be accessed by unauthorized persons.
c. You understand that telehealth-based services and care may not be as complete as face-to-face services. You also understand that if my provider believes you would be better served by face-to-face services, you may be referred to a provider who can provide such services.
d. You understand that you may benefit from telehealth but that results cannot be guaranteed or assured.
e. You understand that you have a right to access my medical information and copies of medical records in accordance with state law.
f. You understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing emergency 911 services in your community.

By signing this consent, you or your personal representative have read and understand this form and you accept its terms and conditions.

_____ _____

Signature Date

_____

Print Name

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