MENTAL HEALTH SOLUTIONS S.C.

Telemedicine Informed Consent Form During COVID-19 Pandemic

DEFINITION: The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) defines telemedicine as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration. Technologies include videoconferencing, the internet, store- and-forward imaging, streaming media, and landline and wireless communications.

NATURE OF TELEMEDICINE VISIT: During the telemedicine visit, details of your medical history, examinations, imaging and/or testing may be discussed using interactive video, audio, and telecommunications technologies. Telemedicine visits may help limit the spread of contagious diseases, including the Coronavirus (COVID-19).

I understand there are limitations with telemedicine visits, such as being able to conduct physical exams, which may limit my provider's ability to diagnose certain conditions.

I understand that a variety of alternative methods of medical care may be available to me and my healthcare professional has explained the alternatives to my satisfaction, and I may choose to opt out of telemedicine in favor of another appropriate and available method at any time.

I understand that, as with any technology, telemedicine has technology limitations which may affect my provider's ability to fully complete a telemedicine visit. In the event of technology limitations, I understand my provider may need to end the telemedicine visit and discuss other treatment delivery options.

During the COVID-19 pandemic, the U.S. Department of Health and Human Services (HHS) has permitted certain telecommunication methods which might not otherwise be permitted. I understand that my healthcare provider will still work to maintain the security of information transmitted.

I agree to participate in a telemedicine visit and authorize the electronic transmission of my medical information and/or video conferencing session. By signing this form, I acknowledge I have read and fully understand the above information.

Signature of Client (14 and older):_____ Date:_____

Printed Name of Authorized Person:_____

Signature of Authorized Person:_____ Date:_____

If signed by a person other than the patient, stated authority to do so:

□ Legal Authority □ Legal Guardian □ Next of Kin □ Parent of Minor □ Power of Attorney