Informed Consent for Telehealth Visit

I hereby consent to receiving treatment through telehealth from my Family Medicine Health Center provider or a qualified member of his or her care team. If patient is a minor, I consent to have the minor (identified below) receive treatment through telehealth. I understand that "telehealth" is the mode of delivering health care services through information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. I understand that telehealth also involves the communication of my medical information, both orally and visually, to health care providers located at Family Medicine Health Center or elsewhere.

I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time 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 understand that receiving treatment through telehealth does not mean I cannot receive in-person health care services, either today or in the future. I understand that there are limitations to the types of treatment that can be appropriately provided via telehealth, and that my provider determines whether or not it is appropriate for me to receive treatment via telehealth.

(2) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. I also understand that there are risks involved in receiving treatment via telehealth, such as interruption of the audio-video connection between me and my provider, or delays in receiving medical treatment because of technological failures.

(3) I understand that in some cases a patient may require an in-person visit following a telehealth visit to adequately assess or treat some health concerns, for procedures, immunizations, or other issues and I also understand that there will be an additional charge if an in-person visit is required.

(4) I understand that the patient must be located within the State of Idaho to participate in a telehealth visit.

I understand that I can discuss any questions that I have with my provider at the beginning of my telehealth visit, that my provider will answer any such questions, and that I may decline to continue the telehealth visit at any time.

By beginning my telehealth visit, I confirm that I have read and understand the information in this Informed Consent, and give my informed consent to receive treatment via telehealth.

Signature of Patient	Date
Print Patient Name	
Signature of Legal Guardian if Patient is a Minor	Date
Print Guardian Name	Relationship to Patient