Katie M Wyss LMSW, LLC
KatieMWyssLMSW@gmail.com
734-926-9189

Telehealth Patient Consent Form

I (name) _____ agree to receive this health care service, (type of service) _____, as a Telehealth service. I understand that the health care practitioner (name) _____ is located in another facility (facility name and address) _____.

A Telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for six months for follow-up Telehealth services with the health care provider.

I also understand that:

- I can decline the Telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the Telehealth service.
- If I decline the Telehealth services, the other options/alternatives available for me, including in-person services, are as follows: **seek alternative providers in your community**.
- The same confidentiality protections that apply to my other medical care also apply to the Telehealth service.
- I will have access to all medical information resulting from the Telehealth service as provided by law.
- The information from the Telehealth service (images that can be identified as mine or other medical information from the Telehealth service) cannot be released to researchers or anyone else without my additional written consent.
- I will be informed of all people who will be present at all sites during my Telehealth service.
- I may exclude anyone from any site during my Telehealth service.
- I may see an appropriately trained staff person or employee in-person immediately after the Telehealth service if an urgent need arises OR I will be told ahead of time that this is not available.

-

I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for six months and will be renewed after _____.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Representative Date

_____ _____
If other than patient, relationship to patient Reason (minor, incompetent, etc.)

_____ _____
Witness Date

Telehealth Consent:

_____ _____
Signature of Person Obtaining Consent Date

Facility Name _____

Facility Address _____

☐ Copy given to patient
☐ Refused