MR # DOB

BASSETT HEALTHCARE NETWORK

NAME

DATE

INFORMED CONSENT FOR SCHOOL-BASED HEALTH CENTER TELEHEALTH SERVICES

H-10797 7/19;12/19 (d:\forms\hosp\.ofm)

Health Center _____

1. I understand that telehealth is the use of electronic information and communication technology to deliver health care services including, but not limited to, the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient, when the patient is located at a different site than the provider.
2. I understand that my child's School-Based Health Center health care provider wishes me to engage in a telehealth consultation or care for medical care, dietary counseling, psychiatric care or consultation with pediatric specialist.
3. My child's School-Based Health Center health care provider has explained to me how the electronic information and communication technology will be used during the consultation and that it will not be the same as a direct patient/health care provider visit since my child will not be in the same room with the health care provider.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties that may lead to an inability to obtain information sufficient for decision making about my child's health problem and that all reasonable precautions will be taken to minimize these risks. I understand that my child's health care provider or my child or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had the alternatives to a telehealth consultation explained to me. In choosing to participate in a telehealth consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. I understand that my child's healthcare information may be shared with other individuals for treatment, payment or operations purposes, in accordance with New York State and Federal Privacy rules and the Notice of Privacy Practices. Others may also be present during the consultation besides my health care provider, and consulting health care provider, in order to operate the communication equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that my child will be informed of their presence during the consultation and will have the right to request the following:
    a. omit specific details of their medical history/physical examination that are personally sensitive to them,
    b. ask non-medical personnel to leave the telehealth examination room, and/or
    c. terminate the consultation at any time.
7. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language that I understand.
8. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my child's care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Bassett Department of Health Information Management at 607-547-3770.
9. I understand that my child has the right to have appropriately trained staff immediately available while receiving the telehealth service to attend to any emergencies and other needs.
10. I understand that I have the right to select another provider and be notified that by selecting another provider, there could be a delay in service and the potential need to travel for a face-to-face visit.

By signing this form, I certify:

a. That I have read or had this form read and/or had this form explained to me,
b. That I fully understand its contents including the risks and benefits of the procedure(s), and
c. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature of Patient/Guardian _____ Date _____
(or person authorized to sign for patient)

If authorized signer, relationship to patient _____

CONSENTS