Online Children's Therapy

Occupational Therapy Just For Kids

DBA Corvallis Children's Therapy & Canadian Children's Therapy

TELEHEALTH CONSENT FORM

CLIENT'S NAME _____ **DOB** _____ **PHONE NUMBER** _____

Provider: Pamela Hood Szivek, OT Registered **Originating Site:** Patient's Home

This form educates and grants permission for telehealth visits. Telehealth utilizes interactive video conferencing to enable a healthcare provider at a distant location to provide assessment, treatment and consultation to me, and to consult with my local healthcare provider. During the telehealth visit:

- Details of my medical history and assessment results may be discussed virtually.
- **No video or audio recording by any party may be done of the session without further written consent of all parties, and must be disclosed to all parties prior to and during the session.** This includes recording by the patient or their representative, by the provider, or by anyone else. The provider may take screen shots or request that I send photos for the medical record.
- **All persons present** during videoconferencing session **must be disclosed** to the provider and the client/guardian, **especially when such persons are off screen.**

POSSIBLE RISKS: Potential risks associated with telehealth use may include and may not be limited to:

- In certain cases, information may be insufficient for medical decision making by the provider without further in-person examination.
- Delays could occur due to interruptions, including those from failures of technology.
- Security protocols could fail, causing a breach of privacy of personal medical information.

RELEASE OF INFORMATION: Laws regarding access to your medical information apply to medical records of this telehealth visit. The session itself is not recorded and the videoconference itself is not a health record. Photos and documents exchanged during, before or after the session are part of the health record. Your provider will make entries into your medical record regarding the visit. Health information will be only shared according to the provider's privacy policy.

DISPUTES: I agree that any dispute arriving from the telemedicine visit will be resolved in the jurisdiction in which I reside, and that those laws shall apply to the dispute.

PROXY: If I am signing this consent on behalf of a minor, I have the legal authority to do so. This use of the first person in this consent agreement includes me, and the person I am representing.

I have read and understand this information and have had an opportunity to ask further questions.
I hereby give my informed consent for the use of telehealth in my health care.

_____ _____

Date Signature of Client or Parent/Guardian

_____

Printed Name of Client or Parent/Guardian