Telepossible – Patient Informed Consent Form

By signing this form, I understand and agree with the following:

Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers include properly licensed and volunteering medical practitioners from the United States. I agree to share my personal information for diagnosis, prescription, and follow-up.

Telehealth/Telemedicine requires transmission via Internet of health information, which may include:

- Progress reports, assessments, or other intervention-related documents
- Videos, pictures, messages, audio and any digital form of data

Information obtained during telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, and healthcare operations. By agreeing to use the telehealth/telemedicine services, I understand, agree, and expressly consent to *Telepossible* obtaining, using, storing, and disseminating to necessary third parties, information about me, including my image, as necessary to provide the telemedicine services.

As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Telepossible employee/provider(s) may also be present and have access to my information for the telemedicine session. This is so they can operate or repair the video or audio equipment used on-site at Ezekiel Center (subject to change). These persons will adhere to applicable privacy and security policies.

I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended. I hereby release and hold harmless *Telepossible* from any loss of data or information due to technical failures associated with the telemedicine service.

I further understand that my provider's advice, recommendations, and/or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. Given the risk of misdiagnosis/mistreatment based on aforementioned factors, I hereby release and hold harmless *Telepossible* and its health care providers from legal liabilities arising from acts of ordinary negligence or omissions committed within the scope of their responsibilities.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.

By signing below, I certify that I am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understood the above statements. I understand that this informed consent will become a part of my medical record.

Patient's Signature _____ Date _____

Patient's Printed Name _____