



INFORMED CONSENT FOR TELEHEALTH CONSULTATION

- Carle Foundation Hospital _____
- Carle Physician Group _____
- Carle SurgiCenter _____
- Hoopeston Regional Health Center _____



imprint

A telehealth consultation has been recommended as a way to facilitate my care. Telehealth allows my condition to be assessed by a specialist who is not in my community. In order to perform the telehealth consultation, the specialist will review information about my condition. My healthcare provider will decide what information will be provided. The information will be transmitted electronically. Electronic transmission of information is like an e-mail but takes place using protected and dedicated communication lines. Information to be transmitted may include patient reports, laboratory results, radiograph reports, and photographs. In some situations, my healthcare provider will receive the specialist's report and will be able to review the recommendations with me.

By signing this agreement, I authorize the electronic transmission of my medical information and/or a telehealth session to _____ (name of healthcare provider completing telehealth consultation) and other persons involved in my medical treatment and care. I understand the specialist providing the telehealth consultation and other persons involved in this telehealth consultation will have access to this information if applicable. I have been advised that the likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small. I understand that this agreement is not intended to describe actual treatment limitations and risks. This agreement is intended only to describe limitations and risks specific to the electronic transmission of information.

I understand that I can withdraw my permission to participate in a telehealth consultation at any time. Although I may choose not to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons, doing so may impair the specialist's ability to understand and address fully my healthcare issue(s). I understand that if I choose not to participate in the telehealth consultation, no action will be taken against me. I am always at liberty to pursue a face-to-face consultation.

I understand telehealth does have limitations. For example, the specialist is not able to palpate (directly examine with one's hands) but may use small special cameras to view close up details during a physical exam. My healthcare provider will address any other questions that I may have about the limitations of telehealth applicable to my specific condition.

I understand that if applicable, medical records of telehealth services will be kept at both the referring site and the consulting site. If I want to obtain copies of my records, I understand that I must contact the appropriate site's medical record office.

I understand that some or all of my medical information may be used for teaching or educational purposes at Carle.

I also agree to have my telehealth medical records reviewed for the purposes of evaluation (data collection, analysis, quality assurance and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers. DECLINE _____ (initials of patient only if declining)

My healthcare provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I have read and agree to a telehealth consultation.

Signature of Patient or Authorized Person

_____/_____
Date Time

Signature of Witness

_____/_____
Date Time

INTERPRETER SERVICES:

I have provided interpretation in _____ of any verbal and/or written information.
(type of language)
including this consent form, that have been provided to the patient/authorized person to consent.

Interpreter: _____
(print full name/badge #)

_____/_____
Date Time

Signature (or if remote source, indicate company used): _____