



## **INFORMED CONSENT FOR TELEHEALTH SERVICES**

Telehealth is a tool used by Middlesex Health Providers to diagnose, consult, treat and educate using interactive audio/video or data communication regarding my treatment. I hereby consent to participating in medical services via the internet (hereinafter referred to as Telehealth).

I understand I have the following rights in connection with Telehealth services provided to me:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person medical services. Any information disclosed by me during the course of my treatment, therefore, is generally confidential. However, I understand that there are, by law, exceptions to confidentiality, including, but not limited to, mandatory reporting of child, elder, and dependent adult abuse, any threats of violence I may make towards a reasonably identifiable person and situations in which I may be a danger to myself or others.

I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I will not record any Telehealth sessions without written consent from the Provider. I understand that the Provider will not record any of our Telehealth sessions without my written consent.

I will inform the Provider if any other person can hear or see any part of our session before the session begins. The Provider will inform me if any other person can hear or see any part of our session before the session begins.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that one or more of my treatment sessions could be disrupted or distorted by technical failures or could be interrupted. In addition, I understand that Telehealth treatment is different from and can sometimes be more limited than in-person medical services which provide for in-person examination and interaction. I acknowledge that if the Provider believes I would be better served by another form of medical services, such as in-person treatment, I will be referred to a Provider in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information with the Provider and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth services by providing written notification to Middlesex Health. My signature below indicates that I have read this Informed Consent form, agree to its terms and thus consent to Telehealth services.

\_\_\_\_\_  
**Patient or/Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Patient**

\_\_\_\_\_  
**Relationship to Patient**