

(VISN or facility name)
(Program name)
Telehealth Consent

Patient's name: _____ SSN: _____

I give permission to my VA telehealth care team to provide home telehealth services to me. _____ has explained the details of these services to me. I will be using _____ as my home telehealth device.

Authorization to obtain and release information

I give permission to my VA telehealth care team to obtain any and all clinically necessary information on where care has or will be provided to me.

I also give permission for my VA telehealth care team to release any clinically necessary information about my health to any individuals that have been or might be involved in my care.

Authorization to collect, analyze, store and share outcome data

I give permission to my VA telehealth care team to collect, analyze, store, and share outcome data from the care I receive and that this may include health information.

I understand that my health information may need to be shared with others inside and outside my VA Medical Center and if so none of this data will identify me.

I understand that occasionally, when required by law, information about me may be shared with others that reveal my identity.

I understand that individuals who are either directly or indirectly involved in my care for the purposes of treatment, billing, and daily operations may review my health information and records.

I understand that I have the right to see my data by written request to my VA telehealth care team.

I also understand that I have the right to refuse my VA telehealth care team to collect, analyze, store, and share my data at any time. By refusing this will not affect my usual VA healthcare but will prevent me from participating in the telehealth program.

Authorization to capture video images during a telehealth visit

I authorize my VA telehealth care team to take photographs or images of me. These images or photographs will be kept confidential and only used for my care and treatment.

Patient responsibilities

- (1) I understand that my VA telehealth care team will be helping my primary care provider, not replacing them. I agree to provide accurate answers about my condition(s), medications, and treatments. I recognize that if I do not answer truthfully or use the equipment as instructed that this may result in serious harm happening to me.
- (2) I understand that while the equipment is in my home I will follow the instructions given to me by my VA telehealth care team about its care. If the equipment becomes damaged I will notify my VA telehealth care team immediately: (phone number to call)

I have read and understand the above information and consent to participate. I agree that the equipment will be returned to the VA when my participation in this program is over.

Patient Signature

Date

Witness

Date