



Informed Consent for Telehealth Services

I, _____, consent to engaging in telehealth with Lake Superior Community Health Center as a part of treatment. I understand that telehealth services may include medical, dental, and mental health evaluation, assessment, consultation, and treatment recommendations. Telehealth will occur primarily through interactive audio and video communications such as ZOOM cloud-based meetings. ZOOM is a HIPAA compliant teleconference format. I understand that this is a limited consent for services in the State of Wisconsin and the State of Minnesota during times when face to face treatment is not deemed feasible or may result in the possible exposure to COVID-19 or a similar situation.

By signing this consent, I am verifying that I understand the following:

1. I have the right to withhold or remove consent for telehealth services at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my visit, is confidential, just as it would be if I were in the clinic. I understand that the visit is transmitted over dedicated lines and cannot be accessed by any unauthorized individuals.
3. I give my consent to be interviewed by the consulting healthcare provider. I also understand that other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained. I understand that I will be informed of any consulting healthcare providers present during my telehealth session.
4. **For Medical or Dental visits:** I understand that a limited examination may take place during the videoconference and that I have the right to ask my healthcare provider to discontinue the conference at any time.
5. I authorize the release of any relevant medical information about me to the consulting healthcare provider, any staff the consulting healthcare provider supervises, third-party payers and other healthcare providers who may need this information for continuing care purposes.
6. I understand that payment for this visit will be the same as an in-person visit. I understand that my insurance will be billed or the sliding fee scale will be applied.
7. In the event the equipment goes down, the provider will attempt to re-establish connection. (Reasonable attempt within 10 minutes). If unable, the provider or authorized personnel will attempt to contact me via telephone to reschedule the appointment. If there is equipment failure during my telehealth visit and I feel I am in crisis or having a safety issue, I will call 911/law enforcement.
8. I agree that certain situations including emergencies and crises are inappropriate for telehealth services. By signing this document, I acknowledge I have been told that if I'm having an emergency, I should immediately call 911 or go to the nearest hospital.
9. I hereby release Lake Superior Community Health Center, its personnel and any other person participating in my care from any and all liability which may arise.

10. I have read this document and understand the risk and benefits of the telemedicine services and have had my questions regarding the services explained and I hereby consent to participate in a telehealth visit under the conditions described in this document.

Patient/Legal Representative Relationship Date

Witness Date

Email Address:
