Dermatology and Laser Institute of Colorado, PC
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# Consent for Telehealth Services

1. **Telehealth Services:** Telehealth is different from traditional care in that the patient and provider do not meet physically in person. In telehealth, medical information is transmitted through electronic communications. Telephone consultation, live videoconferencing, transmission of still images, and patient portals are all considered telehealth services.
    - I agree to evaluation and treatment via telehealth. I understand that my provider will determine whether or not the condition being evaluated or treated is appropriate for a telehealth encounter.
    - I have the right to refuse or stop participation in telehealth at any time and request an in-person appointment.
    - Benefits of telehealth include that the patient and provider can continue health care services when an in-person appointment is not possible or is inconvenient. Telehealth may also help minimize exposure to communicable disease.
    - There are also risks involved in telehealth including, without limit, losing the ability to:
        - perform aspects of a physical examination (for example verifying vital signs, palpating the skin, or using a dermatoscope to examine a skin lesion);
        - provide in-office services such as freezing, injection, biopsy, or other therapy.
    - I understand that a medical evaluation via telehealth may limit my provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my provider's recommendations, including further diagnostic testing such as biopsy, bloodwork, or an in-office visit. I agree to follow-up as necessary with questions or concerns.
    - Our office can provide telehealth services only to patients who are located in the state of Colorado at the time of the telehealth service. I attest that I am located in the state of Colorado and will be present in the state of Colorado during all telehealth encounters with my provider.
    - I understand that the fees for telehealth are the same as for a regular office visit.
    - I understand that the transmission of medical information could be disrupted or distorted by technical issues. The provider and practice are not responsible for any information lost due to technical failure.

2. **Confidentiality:**
    - All confidentiality protections required by law or regulation will apply to my care.
    - To help maintain confidentiality, it is important that all sessions be conducted in a confidential place. I agree to participate in telehealth only while in an area where other people are not present and cannot hear the conversation or see the video and/or photo images.
    - I will be informed of any additional personnel that are to be present, seen or unseen, during the encounter. I must inform my provider of any person other than myself who is present. I have the right to exclude anyone from either location.

- Sessions may not be recorded and patients must seek written permission before recording any portion of the session and/or posting any portion of sessions.
- I agree to use the secure telehealth platform recommended by my provider. I understand that FaceTime, Skype, Zoom or a similar service may not provide a secure, HIPAA-compliant platform.
- I understand that it is important for me to use a secure network. Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided.
- I agree to use end-to-end encrypted email in any email communication with my provider. I understand that if email is not end-to-end encrypted, it is not secure and could expose my private health information.
- There is always a risk that electronic medical communications may be compromised, unsecured, and/or accessed by a third-party. I understand that my provider cannot guarantee that those communications will be kept confidential and/or that a third-party will not gain access to such communications.
- The provider and practice are not responsible for breaches of confidentiality caused by myself or by an independent third party.
- I shall have access to all medical information resulting from the telehealth service as provided by applicable law for patient access to medical records.

3. **Emergencies:**
   - I understand that telehealth should never be used for emergency communication. If an emergency occurs, I will call 911.

I certify that I have read, understand, and agree to the terms in this Consent for Telehealth Services. I understand that telehealth is not a substitute for in person health care services. I understand that telehealth is not appropriate if I am having an emergency. I have had the opportunity to ask questions and all questions have been answered to my satisfaction. I hereby request telehealth services from my provider.

_____ _____/_____/_____
Patient Name Date of Birth

_____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
Physician Signature Date