Woodlands Low Vision Clinic
Telehealth Consent Form

By signing this form, I understand and agree with the following:

Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, medical assistants and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate on the telehealth/telemedicine service, and I agree to share my personal information with such family members, caregivers, legal representatives or guardians. The information may be used for diagnosis, therapy, follow-up and/or education.

Telehealth/Telemedicine requires transmission, via Internet or tele-communication device, of health information, which may include:

- Progress reports, assessments, or other intervention-related documents
- Bio-physiological data transmitted electronically
- Videos, pictures, text messages, audio and any digital form of data

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing and healthcare operations. By agreeing to use the telehealth/telemedicine services, I am consenting to The Woodlands Low Vision Clinic sharing of my protected health information with certain third parties as more fully described in The Woodlands Low Vision Clinic Privacy Policy. I understand, agree, and expressly consent to The Woodlands Low Vision Clinic obtaining, using, storing, and disseminating to necessary third parties, information about me, including my image, as necessary to provide the telehealth/telemedicine services.

As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Individuals other than my clinical care team or consulting providers may also be present and have access to my information for the telehealth/telemedicine session. This is so they can operate or repair the video or audio equipment used. These persons will adhere to applicable privacy and security policies.

Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient or care team.

I hereby release and hold harmless The Woodlands Low Vision Clinic and all members of my care team from any loss of data or information due to technical failures associated with the

I understand and agree that the health information I provide at the time of my telehealth/telemedicine service may be the only source of health information used by the medical professionals during the course of my evaluation and treatment at the time of my telehealth/telemedicine visit, and that such professionals may not have access to my full medical record or information held at The Woodlands Low Vision Clinic.

I understand that I will be given information about test(s), treatments(s) and procedures(s), as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telehealth/telemedicine visit.

I have the right to withhold or withdraw consent to the use of telehealth/telemedicine services at any time and revert back to traditional in-person clinic services. I understand that if I withdraw my consent for telehealth/telemedicine, it will not affect any future services or care benefits to which I am entitled.

All my questions have been answered to my satisfaction.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

Signature of Patient or Patient's Legal Representative **Date and Time**

Printed Name of Patient or Patient's Legal Representative **Relationship to the Patient**

INTERPRETER'S ATTESTATION (if applicable):
I certify that I am fluent in the language of the person providing consent. I certify that I have accurately and completely interpreted the contents of this form, and that the person giving consent has indicated their understanding of the contents.

Signature of Interpreter **Date and Time**