



## Telehealth Consent Form

Telehealth / Telemedicine is a way to visit your healthcare provider without going into the clinic. The visits are held by computer, tablet, or telephone.

This form gives permission for Telehealth communication between AK Rheumatology and

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient DOB

I understand that Telehealth shares my health information electronically. I will inform you if there is any information not to be shared.

I may stop Telehealth visits at any time and still be able to receive care at this office.

I understand that I may have to check with my Insurance plan to see if Telehealth is covered.

I understand that Telehealth visits carry some risks as below, not limited to:

- My computer, tablet, or phone may not be private and secure

- It is my responsibility to make sure my internet is private and secure and to make sure my place is private during visits.

- Technical problems may interrupt the visits.

- My Healthcare provider cannot examine me closely during a Telehealth visit, and this makes it hard to assess or diagnose my issues.

I agree that information shared on Telehealth visits will be kept by the Healthcare providers and facilities involved in my care.

I understand that I will be asked to confirm my identity and current location before these visits.

I also have the right to confirm the identity and credentials of the Healthcare provider.

I agree to follow the Healthcare providers recommendations for Labs, X rays, medications, referrals to other specialists or to come in for in person visit or to go to ER if needed.

By signing below, I agree that I have reviewed the above information and all questions are answered, and I agree to Telehealth visits.

\_\_\_\_\_  
Signature of patient or Legal Guardian/ Representative

\_\_\_\_\_  
Date/ Time

\_\_\_\_\_  
Printed Name Of The above

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

This document is to be signed for possible future appointments through Telehealth if needed.