**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

MR#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MCOxx#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stephens Outreach Center**

**Patient Information and Consent for Telemedicine/TeleHealth**

Telemedicine provides counseling, medical and psychiatric services using interactive audio & video conferencing tools, such as VSEE, in which the medical provider and the client are not at the same location. Telemedicine will allow the client to receive medical care without the need to visit the office and travel long distance.

The interactive electronic systems used in Telemedicine incorporate network and software security protocols to protect the confidentiality of client information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Benefits include, increased accessibility to medical and psychiatric care and patient convivence.

Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; and a lack of access to all the information available in a face to face visit may result in errors in medical judgment. Alternative to Telemedicine include traditional face to face sessions.

**Access to Info**: I have the right to inspect all medical information and this includes telepsychiatry notes. I may obtain copies of this medical record information.

**Confidentiality**: I understand that the laws which protect the confidentiality of medical information apply to telemedicine. My telemedicine visit will not be recorded and all identifying information in the interaction will be kept secure in the same manner as any other private medical information.

**Your Rights:**

1. I understand that the laws that protect the privacy and confidentiality of medical information also apply to Telemedicine;
2. I understand that the Telemedicine platform used by SOC is encrypted to prevent the unauthorized access to my private medical information.
3. I have the right to withhold or withdraw my consent to the use of Telemedicine during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
4. I understand that SOC and its medical providers have the right to withhold or withdraw consent for the use of Telemedicine during the course of my care at any time;
5. I understand that all rules and regulations which apply to the practice of medicine in the State of North Carolina also apply to Telemedicine.

**My Responsibilities:**

1. I will not record any Telemedicine sessions without written consent from a SOC medical provider. I

understand that all SOC providers will not record any of our Telemedicine sessions without my written consent.

1. I will inform a SOC provider if any other person can hear or see any part of our session before the session begins. SOC Clinic providers will inform me if any other person can hear or see any part of our session before the session begins.
2. I understand that I must be a patient active in Opioid Treatment Program to be eligible for Telemedicine services from SOC.

**Patient Consent To The Use of Telemedicine**

I have read and understand the information provided above regarding Telemedicine, have discussed it with a SOC staff member and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Telemedicine in my medical care and authorize SOC to use telemedicine in the course of my diagnosis and treatment.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_