1st DRAFT CY JUN 15, 2011

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

1st DRAFT CY JUN 15, 2011

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE TELEHEALTH CONSENT - Authorization to Receive or Record Telehealth Services

For use of this form, see MEDCOM Suppl XX to AR 40-66; the proponent agency is the Office of The Surgeon General.

OTSG APPROVED *(Date)* *(YYYYMMDD)*

SECTION I – PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYY/MM/DD)
3. E-MAIL ADDRESS:	4. TELEPHONE NUMBER:

SECTION II – TELEHEALTH OVERVIEW

Telehealth is the delivery of healthcare services using audio, visual, and/or data communications technology when the treating healthcare provider and patient are not in the same physical location. Electronically transmitted information may be used for diagnosis, treatment, follow-up, consultation between providers, or patient education. For this application it involves interactive audio and/or video communications and/or recording of those communications.

My provider wishes to engage me in: ☐ Telehealth Video Teleconference (VTC) *(Real time communication)* **OR** ☐ Recording Telehealth VTC *(Recording real time communication)*

For receipt of the following medical service(s): _____

SECTION III – CONDITIONS FOR THE USE OF TELEHEALTH SERVICES

1. The details of your medical history and current condition, including your protected health information (PHI), may be used by or shared with the distant healthcare provider to facilitate telehealth services.

2. The records that result from examination and care via VTC or store-and-forward telehealth is part of your military medical record and is protected as required by the Health Insurance Portability and Accountability Act (HIPAA).

3. Security measures have been taken to ensure that your PHI is protected during electronic transmission and not accessed by unauthorized users. These security measures include the use of a private network and an encryption tool.

4. You are free to choose between a telehealth service and a traditional face-to-face service. Participation in telehealth services is voluntary. You may withdraw your consent to participate in telehealth services at any time without affecting your right to future healthcare treatment and services.

5. In the unusual circumstance that a healthcare provider wishes to record a telehealth VTC encounter, your permission will be required, and you will be asked to provide written informed consent for the recording. This is provided in Section IX of this form.

SECTION IV – LIKELY DIFFERENCES BETWEEN RECEIVING CARE USING TELEHEALTH VERSUS FACE-TO-FACE CARE

Not as many medical services and procedures are available via telehealth as face-to-face care.

SECTION V – POTENTIAL BENEFITS OF USING TELEHEALTH

1. Improved access to specialized medical care that may not be locally available otherwise.

2. Reduced wait time for appointments.

3. Reduced travel time to appointments.

4. Less time away from duty.

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

Name:

DOD ID:

Sponsor SSN last 4:

Raymond W. Bliss Army Health Center, Fort Huachuca, AZ

☐ HISTORY/PHYSICAL

☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION

☒ OTHER *(Specify)*

Telemedicine IBHC Consultation (Telephonic)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

SECTION VI – POTENTIAL RISKS OF USING TELEHEALTH SERVICES

1. Delays in medical evaluation and treatment could occur due to equipment transmission delays or failure.

2. Security measures such as the use of a private network and an encryption tool have been taken to ensure that your PHI is protected and not accessed by unauthorized users. Healthcare providers cannot guarantee but will use reasonable means to maintain the security and confidentiality of the information sent and received via telehealth.

3. Telehealth services are intended to be of benefit but, as with all healthcare interventions, beneficial results cannot be guaranteed or assured.

SECTION VII – ADDITIONAL INFORMATION

[LEGALITY OF CONSENT IS DETERMINED BY THE LAW OF THE STATE IN WHICH THE FACILITY IS LOCATED, UNLESS PREEMPTED BY FEDERAL LAW OR AS MODIFIED IN OVERSEAS LOCATIONS. ANY ADDITIONAL STATE-MANDATED LANGUAGE CAN BE PLACED IN AN ATTACHMENT TO THIS DOCUMENT.]

SECTION VIII – COMPLETE THIS SECTION FOR RECORDING OF VTC ENCOUNTER ☒ NOT APPLICABLE

1. On some occasions, certain procedures may be audiotaped, videotaped, or observed. This may include diagnosis, treatment, follow-up, and/or patient education regarding your medical care.

2. The purpose of this practice is to ensure the provision of high quality services through supervision of the work and/or use in the ongoing program of professional training at this medical center.

Patient Location (Hospital or Facility Name): _____

Referring Provider (Name/Title): _____ Location: _____

Telehealth Service Provider (Name/Title): _____ Location: _____

SECTION IX – PATIENT ACKNOWLEDGEMENT AND AGREEMENT

1. I have read and understand the information in this authorization form. I consent to having medical services provided by telehealth.

2. My healthcare provider has explained the alternative methods of medical care that may be available to me and the likely benefits and risks associated with these alternatives to deliver care in my situation. I have had any additional questions answered to my satisfaction.

3. By signing this form, I acknowledge the advantages and disadvantages associated with using telehealth services and authorize my health care providers to arrange telehealth services for the purpose of providing medical advice, diagnosis, education, consultation between providers, and/or treatment.

4. I understand that I have the right to revoke this authorization in writing at any time.

5. If "Recording Telehealth VTC" is checked in Section II, I consent to, and authorize the production of, auditory recordings, videotape recordings, closed circuit television, or other recorded observations. I understand that all materials and information will be handled strictly in accordance with professionally accepted standards of ethics and confidentiality.

Patient Signature: _____ Date: _____

Relationship of Patient Guardian/Parent *(if other than patient):* _____ ☐ NOT APPLICABLE

Witness Signature: _____ Date: _____

Advising Signature: _____ Date: _____

(Referring provider or authorized representative)