Teton Valley Health
Direct Primary Care

852 Valley Center Dr. • Driggs, Idaho 83422 • (208) 354-1156 • (208) 354-1155 (fax)

CONSENT FOR TELEHEALTH SERVICES

I am the Patient or the authorized representative of the Patient. I consent to the following telehealth services to the Patient:

PATIENT NAME	

The telehealth services will be provided by the following telehealth provider(s): See Back

I understand that the telehealth services will be provided through the use of telecommunication equipment, and that the telehealth provider will be at a different location than the Patient. I agree that the telehealth provider will determine whether or not the condition being diagnosed or treated is appropriate for telehealth services.

The benefits of the telehealth services have been explained to me, including but not limited to, quicker and improved access to medical care; real-time diagnosis and treatment from a distance; efficient medical management; access to specialty providers; and convenience.

The risks associated with the telehealth services have been explained to me, including but not limited to: limited ability to evaluate due to remote nature of visit and the need to follow-up with an in-person visit.

Providing services remotely through the use of telecommunication equipment involves some additional risks, including but not limited to network interruption, poor transmission quality (i.e., poor image resolution), equipment failure, or other technical difficulties that may interfere with the telehealth services, cause the loss of data, or delay the evaluation or treatment. Also, while the telehealth provider implements certain security measures such as encrypting data and requiring passwords, it is possible that information may be improperly accessed and/or disclosed by unauthorized persons.

I understand that persons other than my healthcare provider may be present during the telehealth services such as my local healthcare providers or technicians needed to operate the telehealth equipment. These persons are obligated to maintain the confidentiality of any information obtained.

I understand and agree that certain aspects of the telehealth services may be recorded for purposes of treatment, education, or healthcare operations, including but not limited to video and photographs.

I have read this document, understand the risks, benefits and alternatives of the telehealth services, and have had all my questions answered to my satisfaction. I hereby consent to the provision of such telehealth services to the Patient.

PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE	DATE	TIME

RELATIONSHIP OF REPRESENTATIVE TO PATIENT	WITNESS SIGNATURE	DATE	TIME