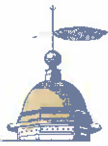

Hamilton

The Joel and Elizabeth Johnson Center for Health and Wellness

The Health Center is happy to announce that we will be utilizing telehealth services to augment the current care that we are able to provide. This will allow students and health center staff to have robust conversations regarding certain health concerns and topics in the comfort of your own space, in a secure, protected manner, while also limiting your exposure to others, and time spent in the Health Center.

Informed Consent for Telehealth Services

Date: ______________________ Student ID#: ______________________

Patient Name: ______________________ Date of Birth: ______________________

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she/they are locate at a different site than the provider.

I understand that the laws that protect the privacy and the confidentiality of patient medical information also apply to telehealth services which may include general medicine and behavioral health. I understand that my information may be shared with other individuals for scheduling and billing purposes and that others may be present during my telehealth visit to assist the healthcare provider.

I understand that, like the delivery of any professional services, there are potential risks associated with the use of telehealth, which include, but are not limited to:

- The healthcare provider may determine that proper care cannot be provided through telehealth and a face-to-face meeting is necessary;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of equipment (through no fault of your healthcare provider);
- In rare cases, security protocols could fail causing a breach of privacy of patient medical information; and
- In rare cases, a lack of complete medical records may result in adverse drug interactions, allergic reactions, or other judgement errors by the healthcare provider.

I understand that I will be responsible for any copayments or coinsurance that may apply to my telehealth visit.

I understand the alternatives to telehealth as they have been explained to me and I choose to participate in telehealth and further understand by doing so that results cannot be guaranteed or assured. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future car or treatment. I may also revoke my consent in writing at any time by contacting the Hamilton College Student Health Center at:

Hamilton College Student Health Center
198 College Hill Road
Clinton, NY 13323
Phone: 315-859-4111
Fax: 315-859-4963

Signature of Patient: ______________________ Date: ______________________
(Or person authorized to sign for patient)

Witness: ______________________ Date: ______________________