

UR Medicine EAP
Life-Work Connections/EAP

TELEHEALTH CONSENT

This consent is for all telehealth services provided by UR Medicine EAP

1. I understand that my Employee Assistance Program (EAP) provider has invited me to engage in a telehealth appointment/consultation to provide assessment and short term counseling.
2. My EAP provider has explained to me that video conferencing technology will not be the same as a direct patient provider visit due to the fact that I will not be in the same room as my EAP provider.
3. I understand that there are risks associated with use of this technology such as interruptions, technical difficulties, and inability to obtain information sufficient for decision making about my problem and that all possible precautions will be taken to minimize these risks. In addition, my EAP provider or I can discontinue the telehealth visit if it is felt that the information obtained through the telehealth connection is not adequate for decision-making or for implementing management of my issue(s). In that event, we will complete the session by phone or schedule an in-person appointment at the EAP location where adequate assessment and short term counseling can be provided,
4. I understand that the information I provide may be shared only with other individuals at EAP for scheduling purposes.
5. The alternatives to a telehealth appointment/consultation have been explained to me.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of the telehealth appointment/consultation
- I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction.
- I consent to this telehealth appointment/consultation.
- I have been provided with the University of Rochester Medical Center and Affiliates Notice of Privacy Practices.

Patient/Parent/Guardian Signature

Date

Time

TO BE COMPLETED BY STAFF

No signature was obtained due to:

Impractical, verbal consent given

Staff Signature

Date

Time

CLIENT E-MAIL CONSENT FORM

Client Name: _____

Client E-mail: _____

Personal Representative*:

Name: _____

Relationship: _____

E-Mail: _____

*see HIPPA Policy OP16 Personal Representative

1. RISK OF USING E-MAIL

Transmitting Client information by E-mail has a number of risks that Clients should consider. These include but are not limited to, the following:

- a) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- b) E-mail senders can easily misaddress an E-mail.
- c) Backup copies of E-mail may exist even after the sender of the recipient has deleted his or her copy.
- d) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
- e) E-mail can be intercepted, altered, forwarded or used without authorization or detection.
- f) E-mail can be used to introduce viruses into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

The Clinician cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. The Client and Clinician must consent to the following conditions:

- a) E-mail is not appropriate for urgent or emergency situations. The Clinician cannot guarantee that any particular E-mail will be read or responded to:
- b) E-mail must be concise. The Client should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
- c) E-mail communications between Client and Clinician will be filed in the Client's permanent medical record.
- d) The Client's messages may also be delegated to another Clinician or staff member for response. Office staff may also receive and read or respond to Client messages.
- e) The Clinician will not forward Client-identifiable E-mails outside of the URMHC healthcare system without the Client's prior written consent, except as authorized or required by law.
- f) The Client should not use E-mail for communication regarding sensitive medical information.
- g) It is the Client's responsibility to follow up and/or schedule an appointment if warranted.
- h) Recommended uses of Client-to-Clinician, E-mail should be limited to:
 1. Appointment requests
 2. Prescription refills
 3. Requests for information
 4. Non-Urgent health care questions
 5. Updates to information or exchange of non-critical information such as laboratory values, immunization, etc...

3. INSTRUCTIONS

To communicate by E-mail, the Client shall:

- a) Avoid use of his/her employer's computer.
- b) Put the Client's name in the body of the E-mail
- c) Put the topic (e.g., medical question, billing question) in the subject line
- d) Inform the Clinician of changes in the Client's E-mail address.
- e) Take precautions to preserve the confidentiality of E-mail
- f) Contact the Clinician's office via conventional communication methods (phone, fax, etc...) if the Client does not receive a reply within a reasonable period of time.

4. CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Clinician and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Clinician may impose to communicate with me by E-mail. I agree to use on the pre-designated e-mail address specified above. Any questions I may have had were answered.

Client or Personal Representative

Date