



## Telehealth Consent- Minor

Telehealth (also known as Telemedicine) involves the use of audio, video, or other electronic communications between you and your healthcare provider. The information provided over telemedicine may be used for diagnosis, therapy, follow-up, and/or education, and can include transmitting your medical records, medical images, audio, and video. Electronic systems used for telehealth incorporate reasonable network and software security protocols and encryption to protect the confidentiality of Protected Health Information and include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption consistent with the Health Insurance Portability and Accountability Act (HIPAA).

### Purpose:

The purpose of this form is to obtain your consent for telehealth appointments for your child with the Clover Enterprises Certified Athletic Trainer(s) and/ or their supervising physician.

### Potential Benefits:

- Improved access to convenient medical care.
- More efficient medical evaluation and management.
- Obtaining the expertise of a distant specialist.

### Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider(s);
- A potential risk is that, depending on your condition or the possibility of technical problems, you may still need a face-to-face consultation.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of the privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors; (Note: the Certified Athletic Trainers do not prescribe nor administer medications)
- If a clinical emergency were to arise, your privacy might need to be breached according to a personalized safety protocol that we will establish during your intake evaluation.

**Special Risks Associated With Home Computers:**

The Clover Enterprises Certified Athletic Trainers and/or their supervising physician cannot control the security of the computer you choose to use for telehealth communication or the location where you choose to use it. Even though a platform is secured over the internet, viruses, malware, spyware, and other programs can be installed on the computer itself without a user’s knowledge and could be used to record the audio and video of a telehealth session without your knowledge. Unencrypted or poorly encrypted wireless networks could also allow someone to intercept the audio and video being transmitted over the network. It is recommended that you only use a privately owned personal computer with up to date antivirus software in a room of your own home that is conversationally private. You assume all risks of the telemedicine session being recorded, seen, and/or heard by unauthorized persons.

**Medical Information and Records:**

All laws concerning your access to medical records and copies of records still apply to telehealth. Dissemination of any identifiable images or information from your appointments will not occur without your consent.

**Confidentiality:**

All existing confidentiality protections under federal and California law apply to information used or disclosed during telehealth sessions. It is your responsibility to ensure that the space you choose to use for the telehealth sessions is private and secure.

**Fees and Billing:**

At this time, there will be no associated costs or fees for your telehealth services.

**Rights:**

You may withhold or withdraw your consent for the telehealth services at any time before and/or during an appointment without it affecting your right to future care or treatment.

**Telehealth Emergency Contacts:**

These are the telephone numbers of your local emergency contacts, in the order that you would like them to be contacted if your child were in crisis (please include at least two trusted friends or family members):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital with an emergency department near me : \_\_\_\_\_

Police precinct near me: \_\_\_\_\_

National Suicide Prevention Lifeline: 1-800-273-8255 and online chat available 24/7

**Please initial the following:**

\_\_\_\_ I agree to inform my provider if my child is in any location other than the address listed on my patient registration forms.

\_\_\_\_ I agree to confirm that the emergency contacts listed above are aware of the fact that I have listed them and are willing to come to my location to assist my child if they were in a crisis.

\_\_\_\_ I agree to have my telephone (at the number listed on my patient registration forms) with me during sessions so that my provider can call me if there is a technical breach or my child is separated from the computer during a session.

\_\_\_\_ I acknowledge that if my child is facing, or maybe facing an emergency that could result in harm to themselves or another person, I am not to seek a telehealth consultation. Instead, I agree to seek care for my child immediately through my local health care practitioner, a hospital emergency department, or by calling 911.

**Parent/Guardian Consent to the Use of Telehealth:**

By signing this form, I agree that I am willing to undertake the risks associated with telehealth in order to take advantage of the convenience it offers. I understand that I can revoke my consent to telehealth for my child at any time without affecting their right to future care or treatment. I have read and understood the information provided above regarding telehealth, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my child's medical care.

I hereby authorize the Clover Enterprises Certified Athletic Trainers and/or their supervising physician to use telehealth in the course of the assessment, diagnosis, and/or treatment of my child.

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School Site: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

Student ID: \_\_\_\_\_ Sport/Activity (If any): \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Email: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_