Nicholls State
University Health Services
P.O. Box 2054
Thibodaux, LA 70310
985.493-2600
Fax 985.493.2601

Name_____

Date_____

Nicholls ID#_____

Date of Birth_____

Telehealth Patient Consent Form

Patient Name_____ **Date of Birth**____-____-____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telehealth consultation.

2. NATURE OF TELEHEALTH CONSULT: During the telehealth consultation:

   - Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   - A physical examination of you may take place.
   - Telehealth will occur primarily through interactive audio, video, telephone, email, and/or other data communications. If one form of technology fails in the course of a telehealth session, an alternate form of communication may be utilized by the medical provider.

3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Louisiana state law apply to information disclosed during this telehealth consultation.

5. RIGHTS: You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. RISKS, CONSEQUENCES, & BENEFITS: There are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the medical professional, that:

   - the transmission of my personal information could be disrupted or distorted by technical failures;
   - the transmission of my personal information could be interrupted by unauthorized persons; and/or
   - the electronic storage of my personal information could be accessed by unauthorized persons.

I agree to participate in telehealth consultations with University Health Services medical professionals.

Patient Signature: _____ **Date:** _____

Patient Representative: _____ **Relationship to patient:** _____