TeleHealth Services Consent Form 2019-2020 School Year

Student Name: _____ **Date of Birth:** _____
School Name: _____ **Grade:** _____

TeleHealth (also referred to as "telemedicine" or "e-health") allows the school health nurse to consult with PanCare medical professionals through the use of telecommunication technology.

By signing this form, I understand the following:

1. I give my consent for my child to be enrolled in the school's TeleHealth Program and that PanCare and its providers can access my child's personal health information if needed.
2. I understand that I have the right to withhold/withdraw my consent to the use of TeleHealth/Telemedicine at any time without affecting my child's right to future care or treatment. Furthermore, I understand that alternative methods of medical/health care may be available, including face-to-face interaction, and that I may choose another alternative at any time.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a TeleHealth/Telemedicine interaction, and may receive copies of this information in accordance with Florida law.
4. I understand that the information disclosed by my child during the course of my child's treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and vulnerable adult abuse.

Electronic communication allows, at a minimum, the use of audio and video equipment for two-way, real time interactive communication between the patient (at the school/originating site) and the healthcare provider (at the remote/distant site). Providers may include primary care practitioners, nurse practitioners, specialists, and/or subspecialists and therapists.

I understand that as with any medical procedure, there are expected benefits and potential risks associated with the use of TeleHealth/Telemedicine that I need to be aware of.

Expected Benefits include the following:

- Improved access to care by enabling a patient to remain at a remote site while receiving professional care from a healthcare provider.
- More efficient medical and health evaluation and management.
- Earlier diagnosis/treatment.

Possible Risks include, but are not limited to:

- As with any healthcare providers, despite reasonable safeguarding efforts, the transmission of my child's medical information could be disrupted or distorted by technical failures resulting in delays in evaluation or access by unauthorized persons.
- As with any healthcare providers, TeleHealth/Telemedicine based services may not be as complete as the parent would prefer. I understand that if my child's TeleHealth/Telemedicine provider believes that my child will be better served by another form of services (e.g. face-to-face services) my child will be referred to another provider and it is my responsibility to ensure that referral instructions are followed timely.
- As with any healthcare providers, in rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the TeleHealth/Telemedicine healthcare provider.
- As with any healthcare providers, in rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- As with any healthcare providers, in rare cases, a lack of access to complete and/or accurate medical records or information may result in adverse drug reactions, allergic reaction, or other judgment error.

I have read and understand the information provided above regarding TeleHealth/Telemedicine and all of my questions have been answered to my satisfaction. I understand any cause of action arising out of this service must do so exclusively in Florida and I knowingly waive my right to access any other legal forum.

I hereby give my informed consent for the use of TeleHealth/Telemedicine in my child's medical/ health care.

***Parent Printed Name*:**_____

Signature of Patient (or person authorized to sign for Patient):_____ ***Date:*** _____

***If authorized signer, relationship to Patient*:** _____

☐ I give consent for my child to receive Mental Health counseling services if referred by BDS. Parent Initials_____

☐ I give consent for PanCare of Florida, Inc. to bill my insurance/Medicaid for services provided. Parent Initials_____