SEVEN RIVERS VASCULAR

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RE: Patient Name (Last) , Patient Name (First) , Patient Name (Middle)
DOB: Patient Date of Birth

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TELEHEALTH CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth servies.

The Purpose of this form is to obtain your consent to participate in a telemedicine consultation.

I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine consult is done through video/audio conferencing (telehealth). And may include the following:
   - Review of your medical history, examinations, and/or test results
   - A physical examination of you may take place.
3. I may ask questions and seek clarification of the procedures and telemedicine technology.
4. I can ask that the telemedicine exam and/or video conference be stopped at any time.
5. I know that there are potential risks with the use of this technology. These can include, but not limited to:
   - Interruption/disconnection of audio/video link
   - A picture that is not clear enough to meet the needs of a consultation

I certify that I have read this form or had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination.

_____ _____

Date Patient Signature