TELEMEDICINE CONSENT AND AUTHORIZATION

McLarenNow

GENERAL CONSENT FOR TELEMEDICINE TREATMENT

I, the undersigned, hereby voluntarily request, authorize and consent to the use of audio, interactive video and/or other electronic communication technology for the purpose of consulting with a health care provider for diagnosis, treatment, therapy, follow up and/or education. I understand that during the visit, details of my medical history and personal health information may be discussed. An assessment of my condition will also take place. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me with respect to the results of the care and treatment that I receive. No part of the visit will be recorded or photographed without my written consent. If photographs are taken for diagnosis, treatment and/or identification, I understand that these photographs and/or recordings may be retained as a permanent part of the medical record and may be used for case studies and education.

BENEFITS, RISKS AND ALTERNATIVES OF TELEMEDICINE TREATMENT

The benefits of telemedicine include having access to medical professionals, information and education without having to travel outside of my community. I understand a potential risk of telemedicine is that because of my specific medical condition, or due to technical problems, a face-to-face visit may still be necessary after the telemedicine visit. Additionally, in rare circumstances, security protocols could fail, causing a breach of patient privacy. The alternative to a telemedicine visit is a face-to-face visit with a physician.

PATIENT RIGHTS

I understand that I may withhold or withdraw my consent to a telemedicine visit at any time before or during the visit without affecting my right to future care or treatment. Additionally, it is my right to contact my primary care or specialty physician for approval before starting any treatment recommended by my telemedicine provider. I understand that non-medical technical personnel may be present during the visit to operate the video equipment. Those individuals are required to maintain the confidentiality of any information provided during the visit. I understand that I will be notified of their presence and that I have the right to ask non-medical personnel to leave the examination room.

PATIENT RESPONSIBILITIES

I understand it is my responsibility to provide the telemedicine professional with accurate, detailed and complete information concerning my medical, physical and mental conditions and other relevant conditions and symptoms pertinent to the services provided. This includes any allergy information, pregnancy/breastfeeding status, or the intent to become pregnant.

NOTICE OF PRIVACY PRACTICES

I understand that the state and federal laws protecting the privacy and confidentiality of medical information also apply to telemedicine, and that information obtained during the telemedicine visit which identifies me will not be disclosed to other individuals or entities without my consent, unless required by law or as outlined in the McLaren Health Care Joint Notice of Privacy Practices. My signature below indicates my acknowledgement that I have received a copy of McLaren's Joint Notice of Privacy Practices or have been given the opportunity to review the Notice electronically.
https://www.mclaren.org/uploads/Public/Documents/mhcnoticeofprivacypractices.pdf

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Student Last Name, First Name Date of Birth

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TELEPHONE CONSUMER PROTECTION ACT

I understand that, from time to time, McLaren, its subsidiaries and affiliates, including, without limitation, the Karmanos Cancer Institute (collectively, "McLaren"), may contact me to discuss any past, current or future services provided by McLaren, as permitted under the Health Insurance Portability and Accountability Act (HIPAA).

I consent and agree to McLaren and its service providers (a) contacting me at any address (including e-mail) or telephone number (including wireless number or ported landline phone number) that I may provide to McLaren; (b) using automated phone dialing systems or prerecorded message calls when contacting me; and (c) sending text messages to my phone number, to carry out the purposes McLaren has identified above. I agree to McLaren sharing my contact information, including my wireless number and e-mail address, with service providers (including a collection agency) with whom McLaren contracts to assist it in pursuing these interests, but I understand that McLaren will not share my phone number(s) with third parties for their own purposes without my consent. I understand that standard telephone minute and text charges may apply.

I further understand that I have the right to revoke my consent to receiving autodialed or prerecorded message calls or texts by contacting a McLaren Customer Representative to inform them of my preferences using the following toll-free number or email address: **(844) 839-3884 or phonecalloptout@mclaren.org.**

AUTHORIZATION TO OBTAIN MEDICATION RECORDS FOR CARE COORDINATION

I understand that it is important for my care providers to know what medications I am currently taking, in order for them to prescribe and provide the appropriate treatment for me. I therefore give permission for McLaren to obtain and review records from any pharmacy (or pharmacies) from which I currently obtain medication(s).

WAIVER OF THE USE OF HEALTH INSURANCE

This is a covered service for Lapeer Community Schools students who attend Rolland-Warner, Zemmer, Lapeer High School and Center for Innovation.

I certify that I have read and understand the information provided above and agree that by signing this form I am bound by its provisions, whether electronically signed by myself or a representative acting on my behalf. I have also read and fully understand and agree to the website terms of use and privacy policy, the payment agreement and the McLaren Joint Notice of Privacy Practices.

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PATIENT Signature (Parent/Guardian, if Minor, or person signing on patient's behalf) Date/Time (**MANDATORY)**

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Relationship if other than patient

TELEMEDICINE CONSENT AND AUTHORIZATION

________________________________ Student Last Name, First Name

____________ Date of Birth