CONSENT TO PARTICIPATE IN A TELEMEDICINE VIRTUAL VISIT AND HIPAA AUTHORIZATION

OVERVIEW: To better meet the needs of our patients, West Cambridge Pediatric & Adolescent Medicine now offers some healthcare services through telemedicine virtual visits (also referred to as "telemedicine" or "telehealth"). During telemedicine virtual visits, your child's health care provider uses 2-way, live video communication technology to assess and treat your child.

1. BENEFITS OF USING THE SERVICE
a. It offers more ways to connect with my child's provider since these visits do not need to be in person.
b. It allows me to get timely and convenient medical advice from my child's provider.

2. POTENTIAL RISKS OF USING THE SERVICE
As with any medical intervention, there are potential risks that come with virtual visits. These risks may include, but are not limited to:
a. Technical issues: A poor Internet connection may reduce my child's provider's ability to do a proper exam, and may affect the assessment or diagnosis of my child's condition and treatment. Delays in evaluation, consultation or treatment may also occur due to problems with technology.
b. Limited access to patient information: My child will not receive a complete physical examination during a virtual visit. Moreover, my child's health care provider's assessment will be based, in part, on the information or images that I give to him or her. Incomplete information may result in reducing my child's health care provider's ability to make an accurate diagnosis. An in-person visit may be needed.
c. Information security: West Cambridge Pediatric & Adolescent Medicine uses end-to-end encryption to keep my child's data safe, but I must do my part, including logging in from a secure Wi-Fi network and having my child's visit in a private location. The security of my information is not guaranteed.

3. ALTERNATIVES TO USING THE SERVICE
I may choose to have in-person visits with my child's provider instead of using this technology.

4. NOTICE OF PRIVACY PRACTICES The laws protecting privacy and the confidentiality of medical information during a physician office visit also apply to telemedicine virtual visits. I can request my child's provider's Notice of Privacy Practices. By signing this authorization, I acknowledge the receipt of my child's provider's Notice of Privacy Practices.

5. PRIVACY AND SECURITY The telemedicine virtual visit service follows patient privacy and confidentiality laws about protected health information (PHI) as outlined by the Health Insurance Portability and Accountability Act (HIPAA). These laws require my provider to get my authorization before sharing information that can identify my child to a third party for purposes other than treatment, payment or health care operations.
a. I understand that use of this service requires the electronic exchange of my child's medical information from one place to another. I understand that I will use this service to send my child's health information and talk with my child's provider.
b. I understand that securely sending my child's information cannot be guaranteed. I understand that electronic exchanges may have errors, delays, disruptions or distortions. I understand that West Cambridge Pediatric & Adolescent Medicine has taken steps to help keep this from happening. I also understand that West Cambridge Pediatric & Adolescent Medicine will protect the security of the information and keep it confidential in accordance with law.
c. Although unlikely, I am aware of the potential risk for PHI to be re-disclosed by the recipient, and no longer protected by the Privacy Rule under HIPAA.
d. I understand the purpose of the virtual visit is for medical use only. Providers do not consent for myself, my child or any individuals participating in the visit to capture, save, store or share any audio or video recordings of any portion of the virtual visit.
e. I understand that a limited visual physical examination will take place during the telemedicine virtual visit and that I have the right to ask my child's health care provider to stop the virtual visit at any time.

f. I understand that some parts of the exam involving physical tests may need a referral to other healthcare providers near me.
g. I understand that my child's health care provider may bill for professional services and for any additional fees related to the telemedicine virtual visit services described above.
h. I understand that even if my child has a telemedicine virtual visit, my child may still need an in-person visit to my child's health care provider or referral to a clinic or specialist for further in-person evaluation and treatment.
i. I understand that my choice to not participate in the telemedicine virtual visit will not interfere with any current or future care that I or my family receives in West Cambridge Pediatric & Adolescent Medicine, and there will be no penalty or loss of benefits.
j. I understand that I may revoke this Authorization in writing; however, information during my child's visit that has already been transmitted prior to my decision to withdraw may not be able to be deleted and/or removed.
k. I understand that I may take back my consent for my child to participate in a telemedicine virtual visit at any time by telling my child's health care provider verbally or in in writing. As long as this consent is in effect, my child's health care provider may provide health care services to my child through a telemedicine virtual visit without me signing another consent form.

PATIENT REPRESENTATIVE/PATIENT SIGNATURE
I agree to participate in a Telemedicine Virtual Visit with West Cambridge Pediatric & Adolescent Medicine and authorize my child's provider to use virtual visit services for direct consultation via 2-way, live video communication technology to assist in making decisions about my child's care. I have read this document carefully and understand the benefits and risks of telemedicine virtual visits. All of my questions have been answered. This Authorization does not have an expiration date.

Patient's Signature _____Name (printed)_____

Time and Date_____

Patient Representative Signature Name (printed)_____

Relationship to patient_____ Time and Date_____

Interpreter/Witness Signature_____

Name (printed)_____ Time and Date_____