Informed Consent Form for Telehealth Services

I, _____, am a patient/client of Community Clinic of Maui, Inc., dba Mālama I Ke Ola Health Center (the "Health Center") and, by signing below, hereby consent to the use of telehealth services, sites, software, devices, and any other platforms (collectively, "Telehealth Services") by any person managing my health care that is an employee, contractor, or affiliate of the Health Center ("Provider").

I understand that telehealth is the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a patient/client who are located in two different locations.

I further understand and acknowledge the following with respect to my consent to the use of Telehealth Services as described herein:

1) I have the right to withdraw this consent at any time without affecting my right to receive future care, services, or program benefits from the Health Center or Provider to which I would otherwise be entitled.

2) There are risks, benefits, and consequences associated with the use of Telehealth Services, including but not limited to, periodic disruptions to transmission caused by technology failures, potential breaches of confidentiality by unauthorized persons, and/or limitations in a practitioners' ability to respond via telehealth to emergencies.

3) There will be no recording or screen capturing taken of any of my telehealth sessions by either the Health Center, Provider, or me. All information disclosed within a telehealth session, and written records pertaining to any such telehealth session, are confidential and considered protected health information ("PHI") under the Health Insurance Portability and Accountability Act ("HIPAA") and may not be disclosed by the Health Center or Provider to anyone without my written authorization, except where the disclosure is permitted and/or required by law.

4) The privacy laws that protect the confidentiality of my PHI, including HIPAA, generally also apply to telehealth, unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I should call 911 if I am having an immediate life-threatening emergency. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, Provider may determine that Telehealth Services are not appropriate and a higher level of care is required.

6) While accessing Telehealth Services, technical difficulties resulting in service interruptions may be encountered. If this occurs, I understand that I should attempt to end and restart the telehealth session. If I am unable to continue my telehealth session because of an inability to reconnect within ten minutes of the initial service interruption, I understand that I will need to call 808-871-7772 to re-schedule my telehealth session.

7) Provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency and I authorize such action by Provider.

Emergency Protocols

I acknowledge that it is in my best interest for Provider to know my physical location during a telehealth session in case of an emergency. I therefore agree to inform Provider, at the beginning of each telehealth session, of the address where I am and will continue to be physically located during the telehealth session. I further acknowledge that, as a condition of my consent to receive Telehealth Services, I will need to provide the name of a person who the Health Center and/or Provider may contact on my behalf in the event of a life-threatening emergency. I understand that this person will only be contacted in an emergency and, if contacted, that this person will be asked to go to my physical location or take me to the hospital. I have provided my emergency contact's information below:

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Emergency Contact Address: _____

I have read the information provided above and discussed it with my care team. I understand the information contained in this form and acknowledge that all of my questions related to my use of Telehealth Services have been answered by the Health Center and/or Provider to my satisfaction.

Signature of Patient/Client (or Parent/Legal Guardian) **Date**

Signature of Provider **Date**