Lago Health
A partnership for better health

TELEMEDICINE HIPAA AND PRIVACY FORM

I understand and agree to participate in a telemedicine encounter with Lauren Gore FNP who is a nurse practitioner, and I understand and agree to the use of said telehealth functionalities in my care.

Risks of participating in a telemedicine visit include, but may not be limited to:

- The connection may fail to work or may be disconnected during an encounter which might result in delays in care
- If it is felt that the care rendered during the visit is not sufficient to appropriately address my problem or provide adequate care I may be required to see my primary care provider in-person or seek out Emergency Care
- In very rare instances, security protocols could fail, causing a breach of privacy of personal and medical information - in these situations, my providers will utilize any and all means necessary to correct the error as outlined in the policies related to HIPAA, Privacy, and Terms of Use and will notify me of the status of such breach and attempts at correction

Benefits of participating in a telemedicine consult include:

- I will have access to medical providers without the costs associated with travel
- I will be able to stay close to home and in proximity to my family and caretakers
- Telehealth will continue to grow and be widely utilized by my providers in the future
- Telehealth reduces overall costs of medicine and is beneficial for patients, insurers, and providers
- The technology needed to perform telemedicine is constantly improving

I understand that ancillary staff, nurses, medical assistants, respiratory therapists, doctors, and other such healthcare employees may be present during the telehealth visit, whose presence may be required for the purposes of obtaining an adequate intake, history, physical examination, or operating equipment. I understand that I have the right to discontinue the telehealth encounter at any time without it affecting my right to further care or treatment. I understand that any and all laws related to medical practice, privacy, and confidentially also apply to telemedicine. I have read this document and understand the risks and benefits as listed above and have had my questions adequately answered. I hereby consent to participate in said telemedicine visit under the conditions described in this document.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosers will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

_____ _____

Patient/Legal Representative Signature Date/Time

_____ _____

Witness Date/Time