Hannibal Regional
Healthcare System

6500 Hospital Drive
Hannibal, MO 63401
573-248-1300

Consent to Participate in Telehealth Services During COVID-19 State of Emergency

Patient Name: _____ Date of Birth: _____

I hereby give my consent to receive medical care ("Services") from health care professionals at Hannibal Regional Healthcare System, Inc. ("Provider") through the use of telehealth technologies when determined appropriate by my clinician, including examination through the use of real-time, interactive audio and video. I understand that the use of telehealth technologies is an alternative method of healthcare delivery and that my clinician will not be physically in the same room with me. I understand that my participation in telehealth services is voluntary and that I may decide to refuse a telehealth service at any time.

I understand that information about my health and these services may be shared for necessary purposes of my treatment, scheduling, payment, and other purposes permitted by law. This is the same way my information is shared when I have an in-person visit with my Provider.

Provider utilizes Zoom for Healthcare because it provides the security required by applicable healthcare laws to protect my privacy. However, I understand that, because Provider and its clinicians are furnishing care during a time of national emergency, I may be offered the option to communicate via other telehealth technologies that may not be "encrypted," or secured, and could potentially be subject to interference or interception by an unauthorized party. I also understand that, despite reasonable efforts on the part of Provider or its clinicians, there are risks and consequences in using telehealth services. The risks include the possibility that transmission of the visit could be disrupted or distorted by technical failures. If your telehealth appointment is disrupted or disconnected, due to technical failures or otherwise, the Provider will make reasonable efforts to re-connect with you.

For my own security, I agree not to share any unique contact information that has been provided to me for the purpose of telehealth with my Provider. I agree that, if possible, I will not conduct my visit in public or allow others to access my computer or phone during my telehealth visit.

By signing this form, I am acknowledging that I have read and understand this consent, had an opportunity to ask questions about this consent, and had all of my questions answered. I understand that I can call 800-845-7407 if I have any questions, concerns, or complaints. I acknowledge that I am the patient, or I am authorized to act on behalf of the patient to sign this form. I understand that if I consent to this document verbally during my telehealth appointment, it has the same effect as if I signed in person.

_____ _____

Patient or Authorized Representative Signature Date

Relationship to Patient, if signed by Authorized Representative: _____

_____

Reason Patient is unable to sign, if signed by Authorized Representative: _____

_____

Printed name, if signed by Authorized Representative: _____

_____