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Informed Consent for Telehealth Services

Telehealth (also referred to as telemedicine/teledentistry) involves the use of electronic communications to enable healthcare providers and patients at different locations to share individual patient healthcare information for the purpose of improving patient care. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data. The laws that protect privacy and the confidentiality of healthcare information (HIPAA) also apply to telehealth. The information may be used for diagnosis, treatment, follow-up, and/or education, and may include any of the following:

- Patient imaging or records.
- Live two-way audio and video.
- Output data from medical devices and sound and video files.

Expected Benefits:

- Improved access to orthodontic care by enabling a patient to remain at a remote site.
- More efficient orthodontic evaluation and management.
- Obtaining expertise of a specialist.

Possible Risks: As with any healthcare procedure, there are potential risks associated with the use of telehealth. These risks, while rare, include, but may not be limited to:

- Information transmitted may not be sufficient (*e.g.* poor resolution of images) to allow for appropriate diagnostic/treatment decision making by the orthodontist.
- Delays in evaluation and treatment may occur due to deficiencies of the technology.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal healthcare information.
- While there are anticipated benefits from the use of telehealth, no results may be guaranteed or assured.

By signing this form, I (undersigned) understand the following:

I have read and understand the information provided above regarding telehealth and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my orthodontic care. I hereby authorize Dr. Whitney Mostafiz, Orthodontist to use telehealth in the course of my orthodontic diagnosis and treatment.

Signed: _____ (Patient or person authorized to sign for patient)

Name: _____ (and relationship to patient, if applicable)

Date: _____