My Country Doctor

## AUTHORIZATION TO COMMUNICATE WITH PATIENT

*Various forms of communication including online, are used by My Country Doctor and some of them are not entirely private and secure. Communications through my EHR, Practice Fusion are encrypted and secure, however telephone/fax, mail, email, text and Skype are not guaranteed secure and may not comply with HIPAA requirements.*

My preferred method of communication in order of preference is (number accordingly):

Personal ☐ mail ☐ phone ☐ fax ☐ email ☐ text ☐ Skype ☐

Please circle any forms of communication that you wish not to be used.

phone fax email text Skype

## TELEMEDICINE

**(SKYPE OR OTHER)**

*Telemedicine is the use of medical information exchanged from one site to another site via electronic communications to improve a patient' health. Videoconferencing and/or direct video communication between the patient and doctor(s) may include still images, reports, remote monitoring of health information and direct video of health issues.*

I understand that:

Initial

_____ the concept of telemedicine and the medium used is for medical purposes only

_____ that two or more providers may be involved including My Country Doctor and the consulting provider and that credentials of any consultant have been verified

_____ that telemedicine is still in its infancy and that there may be difficulties in transmission of data including image quality or other problems beyond the control of My Country Doctor.

_____ that I may stop and/or cancel any telemedicine procedure at any time and may arrange for a face to face conference with the provider.

_____ that the risks and limitations of telemedicine have been explained to me and that there are no guarantees associated with this technology.

_____ that the telemedicine conference may not always substitute for a face to face consultation and this decision is at the discretion of My Country Doctor.

_____ I agree that telemedicine may be used only as an adjunct to my care at My Country Doctor.

# USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize My Country Doctor to be able call phone number _____and leave the following information:

☐ Test and exam results

☐ Only the following records or types of health information
_____

☐ Details about my next appointment

☐ **I DECLINE.** Please do not leave any messages

I hereby authorize the following persons to accept this information:

_____

_____
Name relationship phone number

This authorization expires (date) _____ and may be revoked at any time.

*Initial*

_____The details of communication have been explained to me in terms I understand.

_____ Alternative methods of communication are available to me.

_____ I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important to understand. These risks include, but are not limited to:

- *Online communication can e-forwarded, intercepted or even changed without my knowledge*
- *It is easier to falsify than handwritten or signed hard copies. Backup copies may exist on a computer or in cyberspce, even after both of us have deleted our copies.*
- *I will use a secure network, I will not use standard e-mail or e-mail systems provided by my employer. I understand that employers have a right to inspect and keep online communication transmitted through their system.*
- *Online communications become a part of my medical record.*

_____ I agree to take precautions to keep online communications confidential, including, but not limited to the following:

- I will keep my passwork confidential
- I will not sotre messages on an employer-provided network
- I will not leave messages on my screen for others to view.
- I will review my messages before sending to make sure that they are clear and that all relevant information is included
- I will update my contact information as soon as it changes.

_____ I understand that:

- I am responsible for taking steps to protect myself from unauthorized use of my online communications. The doctor is not responsible for breaches of confidentiality caused by an independent third party or me.
- I must follow the procedures that the doctor implements to allow him to verify my identity in connection with online communication. I acknowledge that failure to comply with these procedures may terminate our online communication.
- that online communication cannot be used for emergencies or time sensitive matters.
- that online communications cannot be used for highly sensitive medical information such as management of HIV/AIDS, STDs, or addiction treatment.
- That it is my responsibility to determine if an unanswered online communication was received.

_____ I acknowledge that I have read and fully understand this consent form, including the risks associated with online communications, the doctor has answered all my questions and that all lines were filled in prior to my signature

For communications between My Country Doctor and staff and _____

_____ _____

Patient or legal representative relation to patient

_____ _____

Print patient name witness

I certify that I have fully explained the nature of this agreement to the patient/legal representative, have answered ll questions fully, and I believe that the patient/legal representative is competent and fully understands that which was explained

_____

R. Paul Ferenchak, MD

_____ copy given to patient _____original in chart