

Dalit Szkolnik MA, RD, LD/N, CEDRD-S

Telehealth Informed Consent Form

I _____ (client's name), hereby consent to engage in telehealth with Dalit Szkolnik as part of my programming. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Florida or outside of Florida that I have signed releases for communication.

I understand that I have the following rights with respect to telehealth: 1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my nutrition treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; expressed threats of violence toward myself. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

3) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my clinician, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services.

4) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

5) I understand that if I am in need of emergency mental health services, I may contact my local emergency room at _____.

6) I have read and understand the information provided above. I have discussed it with Dalit Szkolnik, and all of my questions have been answered to my satisfaction.

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Waiver

I am aware that telehealth services are being offered by Dalit Szkolnik MA, RD, LD/N, CEDRD-D. Please sign below to indicate that you have read and understand the information in this agreement

Print Name _____ Date: _____

Patient's Signature or Guardian's Signature _____