# Consent for Telehealth PEP/HIV Rapid/STD Services

## (Individuals 18 and Over)

You voluntarily agree to receive PEP/HIV Rapid/STD care, including counseling, referral and treatment services from Whitman-Walker Health ("WWH") via telehealth and authorize WWH to provide such care as necessary and advisable for you.

Your telehealth visits will be conducted with the use of real-time interactive two-way audio, video or other electronic communications. Whitman-Walker Health has taken steps to protect the security of information disclosed during the session, but Internet security and privacy are not guaranteed. You understand that (1) security protocols could fail, potentially causing a breach of your protected health information, (2) information you transmit through telehealth technology may be insufficient to allow for appropriate medical decision-making by your provider (for example, poor image resolution); or (3) failures of equipment (for example, servers, devices) or infrastructure (for example, communications lines, power supply) may cause delays in medical evaluation and treatment, or loss of information, and you agree to hold Whitman-Walker Health harmless for any loss of protected health information that occurs due to technological failure.

There are potential risks to telehealth, such as technological interruptions, unauthorized access, and technical difficulties. Your provider will obtain or confirm your contact information in order to reach you in the event of a technical issue.

Having a telehealth visit is your choice. Even if you have agreed to the session, you can change your mind about participating in this or future telehealth sessions. You have the right to withdraw your consent.

Your provider may require an in-person examination before or after diagnosing or prescribing a treatment plan.

If you are experiencing a medical or mental health emergency, you will be asked to immediately call 911 or go to the nearest emergency room.

You will participate in telehealth sessions at a different location from your WWH provider. You acknowledge that a typical physical examination and testing may not be possible prior to the prescribing of medications. If testing is required, you understand that you will be referred by WWH to LabCorp for testing.

You understand that the medications that may be prescribed based on the telehealth screening process and/or any testing that you may need are of minimal risk and based on established medical criteria. You understand that medicine is not an exact science and there are no guarantees that can be made regarding outcomes and results of these examinations and treatments.

You understand that it is important for you to provide the most accurate medical history and responses to screening questions as possible in order to support diagnosis and treatment.

You have been informed that if you are referred by WWH for HIV testing at your provider's discretion and your initial Rapid Test result is reactive (preliminary positive), a Multispot and/or a PCR test may be performed for confirmation of your status and the test results will be a part of your electronic medical record. You understand

that WWH will follow up with you and offer to help you with medical treatment or emotional support as needed based on your test results.

**You understand that if you have requested that an HIV test kit be sent to your home, you are required to attend your telehealth visit before taking the test, rather than taking the test on your own. You understand that if you fail to keep your appointment you will not be eligible to have an HIV testing kit sent to your home in the future.**

Whitman-Walker Health considers your protected health information to be confidential and will not share it with anyone outside of WWH without your consent unless permitted or required by law. You have been informed, for example, that if you are referred for testing and test positive for HIV or any sexually transmitted disease, your name and other information about you will be reported to the public health authorities as required by law.

You are aware that WWH participates in health information exchanges with other hospitals and health centers located in the metropolitan area, including the Chesapeake Regional Information System for our Patients (CRISP) and the Capital Partners in Care Health Information Exchange (CPC-HIE). You understand that your health information will be shared with these exchanges. You understand that information about you is being shared with providers and public health officials outside of the health center for treatment purposes, in order to better coordinate your care, and to assist providers and public health officials in making more informed decisions. You understand you have the right to "opt-out" of health information exchanges at any time by requesting, completing and submitting a copy of WWH's "opt-out" form.

**BY SIGNING YOUR NAME BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ (OR HAVE HAD READ TO YOU), AND UNDERSTAND EACH OF THE SEPARATE PARAGRAPHS ABOVE, YOU HAVE HAD A CHANCE TO ASK WHITMAN-WALKER HEALTH STAFF ANY QUESTIONS YOU MAY HAVE, AND YOU CONSENT TO THE TELEHEALTH SERVICES AND TREATMENT PROVIDED TO YOU BY WHITMAN-WALKER HEALTH.**

**This Consent lasts for as long as telehealth services continue, unless you exercise your right to withdraw your consent at any time.**

**If you are not able to place a wet signature or electronic signature on this Consent and return it to Whitman-Walker Health, you will verbally inform Whitman-Walker Health that you have reviewed this form and provide your verbal consent. Whitman-Walker Health will document your consent to telehealth services on this form and place it in your electronic medical record.**

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| **Printed Name of Patient:** | **Date of Birth:** |
| **Signature:**<br>*(If applicable)* | **Date:** |
| **Patient Location for Telehealth Visits (list state):** | |
| **Name of WWH staff member who obtained verbal consent on behalf of patient:** | **Date:** |