INTEGRATING
WESTERN MEDICINE,
NUTRITION AND
EASTERN TRADITIONS

THE CENTER FOR
INTEGRATIVE
MEDICINE

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MICHAEL HIRT, M.D., A.P.C.
DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE
DIPLOMATE AMERICAN BOARD OF NUTRITION

Consent for Telehealth Services

I, _____ (name of patient or guardian) hereby consent to engaging in telehealth with Michael Hirt, M.D. APC, as part of my medical care. 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 information, both orally and visually, to healthcare practitioners located both in California and outside of California.

I understand that I have the following right with respect to telehealth:

1. I have a 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 therapy 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; and where I make my my mental and emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without any 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 medical professional, that: the transmission of my medical information could be disrupted or distorted by technical failure; the transmission of my medical information could be interrupted by unauthorized persons; and/or 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. I also understand that there are potential risks and benefits associated from any form of medical care, and that despite my efforts and the efforts of my medical professional, my condition may not improve, and in some cases may even get worse.
4. I understand that I may benefit from telehealth, but that the results cannot be guaranteed nor assured.
5. I understand that I have a right to access my personal and healthcare information.
6. By signing this document, I agree that certain situations including emergencies and crises are inappropriate for telehealth medical services. If I am in crisis or in an emergency, I will immediately call 911 or go to the nearest emergency treatment center.

I have read and understand the information provided above. I have discussed any concerns I have with the appropriate members of my medical and legal advisory team(s), and all questions regarding the above matters have been answered to my satisfaction. My signature below indicates that I have read this Consent and agree to its terms.

Name/DOB:

Signature:

Date: