Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale
Québec

This box must contain: File number, surname, first name, date of birth, NAM, mother's name, mother's first name, father's name, father's first name

CONSENT TO THE USE OF TELEHEALTH TO RECEIVE CARE AND SERVICES

Clinical Directorate _____ Program _____ Site _____

Telehealth enables remote health care and services. The chosen technology will meet my needs and is suited to my health condition.

I, the undersigned, _____, receiving care and services from the Centre intégré universitaire en santé et services sociaux de la Capitale-Nationale, hereby confirm that I have received the necessary information to sign this consent, attesting that I agree to receive the care and services required by my health condition via telehealth.

- I understand that my personal information will be kept confidential and that only the professional(s) or administrative staff who require the information to provide health or social services will have access to it.
- I understand that my health and social services information is protected and used in accordance with the provisions of the "Act respecting health and social services information (CQLR, c. R-22.1)".
- I understand that my health and social services professional may electronically receive or transmit the health and social services information required for the care or services provided through telehealth.
- I understand that all necessary measures will be taken to ensure the security of health and social services information and images during their electronic transmission and their storage, in digital form, on servers located in Québec. I acknowledge the potential risks of confidentiality breaches and data loss associated with electronic information transmission, which I accept.
- I understand and accept the risks associated with the use of telehealth.
- I agree that the information collected during this virtual service can be used, while maintaining the confidentiality of my personal data, to evaluate the quality of the service and make improvements.
- I understand that in certain cases, following care and services provided via telehealth, the health and social services professional may deem it necessary for an in-person examination to be conducted. I will then have the option to consent, or not to the appointment offered to me.
- I must inform the health and social services professionals responsible for my care if I am unable to attend my telehealth appointment or if I experience any issues with the technology.
- I acknowledge that I have received and understood information regarding the use of telehealth, if applicable. https://telesantequebec.ca/patient/patient-rencontre-virtuelle/

NAME: FOLDER NO.

Duration of Consent

The consent is valid for the entire duration of my episode of care and services from the date this form is signed. I understand that I can revoke this consent verbally or in writing at any time by contacting the health and social services professional overseeing my care. If applicable, a process is in place to ensure the continuity of my care and services.

Obtaining consent

- I consent to the use of telehealth as a means of receiving the care and services required by my health condition.
- I confirm that I have understood and received the necessary explanations about telehealth.

☐ **In the presence of the user**	☐ **Remotely, verbally**
Date _____ Signature _____ YYYY/MM/DD User or authorized person If authorized person: Relationship to the user: _____ Date _____ Signature _____ YYYY/MM/DD Occupation _____	As health and social services professional, I confirm that I have obtained the user's verbal consent prior to the use of telehealth as a means of receiving care and services. Date _____ Signature _____ YYYY/MM/DD Occupation _____

Revocation of consent

- I hereby declare that I revoke my consent to the use of telehealth as a means of receiving my care and services.
- I understand that I will receive my care and services through alternative arrangements that I have agreed upon with my health and social services professionals. These arrangements are as follows:

_____

☐ **In the presence of the user**	☐ **Remotely, verbally**
Date _____ Signature _____ YYYY/mm/DD User or Authorized person If authorized person: Relationship to the user: _____ Date _____ Signature _____ YYYY/MM/DD Occupation _____	As health and social services professional, I confirm that I have obtained the user's verbal consent to revoke their consent to the use of telehealth as a means of receiving care and services. Date _____ Signature _____ YYYY/MM/DD Occupation _____

Consent will be archived in the medical record for a period of five years.