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

This box must contain: File no., last name, first name, date of birth, HIN, mother's last and first name, father's last and first name

# CONSENT TO THE USE OF TELEMEDICINE FOR THE DELIVERY OF CARE AND SERVICES

**N.B. Please ensure that those signing this form are authorized to do so in accordance with existing legislation. As relevant, please mention in which capacity (curator or legal guardian) the person is authorized to sign. In such instances, request a proof of title.**

As a recipient of care and services from the Centre intégré universitaire en santé et services sociaux de la Capitale-Nationale, I, the undersigned, _____, hereby consent to receiving care and services for my health condition via telemedicine.

Telemedicine involves the use of information and communications technology to deliver care and services. The technology used is adapted to my needs based on my health condition.

- With telemedicine, I can receive care and services remotely, in a way that facilitates the delivery of such care and services for myself, my friends and family and the health workers and professionals working with me. However, telemedicine cannot at any time be a substitute for some in-person care and services. The health workers and professionals responsible for my care may, in certain cases, ask me to meet them in person for an appointment, if need be.
- I understand that, to confirm my identity, the health workers or professionals need to ask to see identification.
- I understand and believe in the importance of providing true and accurate information on the state of my health so that I may receive quality care and services that meet my needs.
- I understand that should I not provide true and accurate information on my state of health, the CIUSSS de la Capitale-Nationale cannot in any way be held responsible.
- I must inform the health workers or professionals responsible for my care if I am unable to attend a telemedicine appointment for my care and services or if I experience technical difficulties with the technology used.
- I acknowledge having received and understood the instructions on the use of the equipment, if relevant.
- I acknowledge having been informed of the risks associated with the use of telemedicine, including, the deficiency of the equipment, the possibility of the loss of information or a breach in privacy. I understand and accept these risks.
- I understand that the institution takes all reasonable measures to ensure the security of the information shared during the delivery of my care and services.
- I understand that the health workers and professionals who provide care and services via telemedicine can share and send information and documents from my user file to my care and service team when required as part of my clinical follow-up.
- I have been informed that the information will be kept in my personal user file in accordance with the laws of the province or territory.
- My consent is valid for the duration of the care and service delivery.
- I can withdraw from the care and services offered via telemedicine at any time by notifying the health worker or professional responsible for my follow-up via telemedicine. Should this occur, a process is in place to ensure the continuity of my care and services.

Name: File no.:

**Duration of consent**

Consent will be valid for the entire care and service episode from the date on which this form is signed. I understand that I can withdraw my consent verbally or in writing at any time by speaking with the health worker or professional responsible for my care.

**Consent to the use of telemedicine**

- I consent to the use of telemedicine for delivery of the care and services I need based on my health condition.
- I acknowledge having understood and received the necessary explanations on telemedicine.

| ☐ **In the presence of the user** | ☐ **Remotely and verbally** |
|---|---|
| Date _____ Signature _____<br>yyyy/mm/dd User or authorized representative<br><br>Date _____ Signature _____<br>yyyy/mm/dd Health worker or professional | • As a health worker or professional, I confirm having obtained the verbal consent of the user before using telemedicine for the delivery of care and services.<br><br>Date _____ Signature _____<br>yyyy/mm/dd Health worker or professional |

**Withdrawal of consent**

- I hereby confirm that I withdraw my consent to the use of telemedicine for the delivery of my care and services.
- I understand that I will receive my care and services by other means as agreed by me and my health workers or professionals. These other means are as follows: _____

_____

| ☐ **In the presence of the user** | ☐ **Remotely and verbally** |
|---|---|
| Date _____ Signature _____<br>yyyy/mm/dd User or authorized representative<br><br>Date _____ Signature _____<br>yyyy/mm/dd Health worker or professional | • As a health worker or professional, I confirm having been informed verbally by the user that he or she wishes to withdraw consent to the use of telemedicine for the delivery of care and services.<br><br>Date _____ Signature _____<br>yyyy/mm/dd Health worker or professional |