VIRTUAL CARE / TELEHEALTH CONSENT FORM

Care pathway: care and services delivered via telehealth by MHI

Virtual care (or telehealth) refers to health and social services provided remotely using technological tools.

In order for my healthcare professional to diagnose or perform the required follow-up remotely, I understand that:

- My follow-up may take different forms, depending on what best suits my health situation and the recommendations of my healthcare professional. For example, it may include :
    - Video call appointments (individual or group)
    - Tools to monitor my health at home (such as an app or a connected device)
    - Educational resources available online
    - Sharing insights among healthcare professionals

- I will receive specific explanations based on the technologies I will need to use.

- In some cases, the physician or healthcare professional may deem it necessary to conduct an in-person examination. In such cases, I will be given the opportunity to decide whether or not to accept the offer of an appointment.

- I will receive electronic communications containing information related to my telehealth service.

- My physician or healthcare professional may electronically receive or transmit my medical information to another professional, such as medical reports, photos, videos, health questionnaires, etc.

- All necessary measures will be taken to ensure the security of my medical information during electronic transmission and storage. However, I understand and accept that certain risks exist, such as breaches of confidentiality or potential data loss.

- All information related to my care will remain confidential and stored in my medical record. It will be accessible only to healthcare professionals involved in care pathway.

Duration of consent

This consent is valid for the entire duration of my care period and services, starting from the date of signature of this form. I understand that I may withdraw my consent at any time, verbally or in writing, by contacting my physician or healthcare professional.

Obtaining consent

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

☐ **In the user's presence**

Date : _____ /_____ /_____ Signature : _____
YYYY MM DD *User or authorized person*

Date : _____ /_____ /_____ Signature : _____
YYYY MM DD *Healthcare professional or staff member*

☐ **Remotely, verbally**

As a healthcare professional or staff member, I confirm that I have obtained the user's verbal consent to receive care and services through virtual care.

Date : _____ /_____ /_____ Signature : _____
YYYY MM DD *Healthcare professional or staff member*

Revoking consent

- I hereby revoke my consent to the use of virtual care as a means of receiving my care and services.
- I understand that I will receive my care and services according to other terms agreed upon between me and my physician or healthcare professional.

☐ **In the user's presence**

Date : _____ /_____ /_____ Signature : _____
YYYY MM DD *User or authorized person*

Date : _____ /_____ /_____ Signature : _____
YYYY MM DD *Healthcare professional or staff member*

☐ **Remotely, verbally**

As a healthcare professional or staff member, I confirm that the user has verbally communicated the decision to revoke consent to virtual care as a means of receiving care and services.

Date : _____ /_____ /_____ Signature : _____
YYYY MM DD *Healthcare professional or staff member*