FORM A: CONSENT FOR TELEMEDICINE SERVICES

Student Name: _____ Date of Birth: _____

Location of Student: _____

Primary Care Physician Name and Location: _____

Student's Pharmacy Name and Location: _____

Insurance Name: _____

Insurance Holder Name and DOB: _____

Insurance Policy Number _____ Group Number _____

Introduction

Canton City School District ("Canton City") has established a program to offer students medical care through telemedicine. The goal of the telemedicine program is to enable healthcare practitioners located at Aultman Orrville Hospital and Aultman designated affiliates ("Aultman Orrville") to provide consultations and related services, through telemedicine, to students located at Canton City's locations. Practitioners may include physicians, primary care practitioners and/or licensed nurse practitioners, specialists, and/or subspecialists.

Expected Benefit of Telemedicine Services:

- Improved access and efficiency to medical care by enabling a student to remain in his/her school while the Practitioner consults from Practitioner's distant/other sites.

Possible Risks of Telemedicine Services:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the Practitioner and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By signing this form, I understand and acknowledge the following:

1. I understand that I have the right to withhold or withdraw my consent to use telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
2. I understand that a variety of alternative methods of medical care may be available to me and that I may choose one or more of these at any time.
3. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located at a different location than me, and details of my medical history, examinations, x-rays, and tests may be discussed with the medical practitioner who is at a different location than me. I understand that I may

expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

4. I have received, or have been offered, a copy of Aultman Orrville's Notice of Privacy Practices. I understand I can obtain a copy of the Notice of Privacy Practices by going online to: http://aultmanorrville.org/Patient-Information/resources/patient-privacy.

PLEASE INITIAL ONE:

___**I hereby permit** Aultman Orrville to provide the student with telemedicine services with or without me being present or participating.

___**I hereby do not permit** Aultman Orrville to provide the student with telemedicine services without me being present or participating. **I want to be present or participating in the visit.**

___**I hereby do not permit** Aultman Orrville to provide the student with telemedicine services.

I understand if I have not chosen to initial an option, I am waiving my right to be present or participating with the student for telemedicine services.

I consent for the undersigned student to receive Telemedicine consultation services. I understand that confidentiality between the student and the Practitioners will be ensured in specific instances in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. Telemedicine consultation services may include, but are not limited to:

- Prescribing of medications
- Medically prescribed basic laboratory tests based upon Provider's assessment
- Referrals for service not provided at the school-based wellness center
- Health education and risk prevention counseling

I understand that if this form is not signed and returned, then no telemedicine services will be offered to the student. I further understand and agree that this informed consent for telemedicine services will suffice as informed consent for future telemedicine services rendered to student.

I have read this Consent and the Notice of Privacy Practices or had them read to me. I understand what these documents say.

Student Signature: _____ Date: _____
(If Student is Over Age 18)

Parent/Legal Guardian* Signature: _____ Date: _____
(If Student is Under Age 18)

*If signed by a Legally Authorized Representative, provide your name and describe your authority to act for the individual below (e.g., parent, legal guardian, healthcare power of attorney, etc.).

FORM B: HIPAA AUTHORIZATION

AUTHORIZATION FORM
Student Authorization for Use and Disclosure of Protected Health Information

StudentName: _____("Student") Dateof Birth: _____

By signing this form, I hereby authorize Aultman Orrville Hospital and Aultman designated affiliates ("Aultman Orrville") to disclose health information about Student to any employee of the Canton City School District ("Canton City") and to Student's parents/authorized representatives for treatment, payment, or healthcare operations. I understand that any health information disclosed by Aultman Orrville to Canton City pursuant to this Authorization may be incorporated into Student's education records and may be accessed by others who are legally permitted to view such records.

This authorization permits Aultman Orrville to use and/or disclose protected health information about Student, including, without limitation, all notes of physicians, nurses, psychologists, counselors. and other persons who have provided or who are providing health care to the undersigned individual, all radiology and pathology records, and other sensitive information (including HIV/STD information, genetic testing information, mental health information, and alcohol and drug abuse information). Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act ("'HIPAA'").

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Aultman Orrville Hospital, ATTN: Medical Records Department, 832 South Main Street, Orrville, OH 44667. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this Authorization. Aultman Orrville will not condition my treatment or payment for my treatment on whether I provide authorization for the requested use or disclosure. I also understand I have the right to a copy of this Authorization.

I understand that information used or disclosed pursuant to this Authorization may be used or disclosed by the recipient and may no longer be protected by federal or state law.

I have read this form or have had it read to me. I understand what it says.
Student Signature: _____ Date: _____
(If Student is Over Age 18)

Parent/Legal Guardian* Signature: _____ Date: _____
(If Student is Under Age 18)

*If signed by a Legally Authorized Representative, provide your name and describe your authority to act for the individual below (e.g., parent, legal guardian, healthcare power of attorney, etc.).

FORM C: FERPA AUTHORIZATION

Student Name: _____ ("Student") Date of Birth: _____

The purpose of this Authorization is to permit Canton City School District ("Canton City") to provide all personally identifiable information contained in the Student's educational records (including any health-related or other information in the records maintained by the Canton City school nurse) to (i) Student's parents and/or Legally Authorized Representatives (unless restricted by law) and (ii) Aultman Orrville Hospital or Aultman designated affiliates ("Aultman Orrville") so that Aultman Orrville can provide telemedicine services to Student.

The Family Educational Rights and Privacy Act ("FERPA") is a Federal Law that protects the privacy of student education records. In accordance with FERPA, Canton City will disclose information from education records with the Student's, or (in the case of a minor) a Student's Legally Authorized Representative's, written consent.

By signing this document, I am giving consent that Canton City officials may provide and discuss the entire contents of Student's education records, including personally identifiable information from such records, with Aultman Orrville representatives. I understand that I may revoke consent at any time in writing to: **Canton City School Nurse, 305 McKinley Ave NW Canton, OH 44702.**
I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this Authorization.

I have read this form or have had it read to me. I understand what it says.

Student Signature: _____ Date: _____
(If Student is Over Age 18)

Parent/Legal Guardian* Signature: _____ Date: _____
(If Student is Under Age 18)

*If signed by a Legally Authorized Representative, provide your name and describe your authority to act for the individual below (e.g., parent, legal guardian, healthcare power of attorney, etc.).