**CONSENT FOR PATIENT/FAMILY TELECONFERENCE (OWN DEVICE)**

This form is to be used when a CoxHealth patient requests to use CoxHealth owned electronic devices to teleconference with friends or family at another location.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Software: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing this form, I acknowledge I have requested to contact my friends and/or family using commercial teleconferencing software while I am a patient of CoxHealth.** I understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, the software selected on this form is not encrypted and, despite reasonable efforts to protect the privacy and security of electronic communications, it is not possible to completely secure the information. I understand electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge of the sender. Despite this, I choose to utilize this manner of communication.

I understand this mode of communication is only to be used within my patient room and that no patients or employees are to be visible at the time of transmission. I understand CoxHealth employees will not actively participate in the teleconference and I will not turn the camera toward them during the teleconference if they are present in the room. I understand this mode of communication is purely social and shall not be used to show procedures, births, or for allowing my friends/family to communicate with my physicians or care staff. I understand I am to keep the camera focused on myself and not my room or other environment. I understand I am to ensure the recipient of the electronic communications is not to record or take screenshots during the communications. I understand that if I do not adhere to the limitations in this paragraph, the teleconference will be halted.

I understand I might share sensitive or protected health information via teleconference and it is my choice to share that information. I understand that the use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties. I understand CoxHealth cannot control the information on the receiving end of this communication and that information might be shared with others I do not know are listening or viewing. I understand CoxHealth is not liable for any disclosures resulting from my choice to use this mode of communication and I assume all risks and consequences from my decision to share my information in this manner.

**ACKNOWLEDGEMENT**

I have had an opportunity to read and consider the contents of this Consent for Patient/Family Teleconference.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this consent is being signed by a personal representative/Guardian/ Legal Representative on behalf of the individual, please complete the following:

Personal Representative’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Individual:\_\_\_\_\_\_\_\_\_\_\_