

 	CONSENT TO USE ELECTRONIC / AUDIO-VISUAL / COMMUNICATION & RECEIVE VIRTUAL CARE	Client Name:
		Identifier:

- I am a client/substitute decision-maker of a client of VHA Home HealthCare or VHA Rehab Solutions (together, “VHA”).
- I understand that it is VHA’s general policy not to permit service providers to communicate with or for clients through electronic means because privacy and security cannot be fully guaranteed. This is because, when using electronic forms of communication, it is possible for persons other than VHA staff and me to intentionally hack into or inadvertently access the electronic communication. I further understand that certain electronic applications, including those that I may use with VHA, process information outside of Ontario and are governed by the laws of those other jurisdictions.
- I understand that VHA service providers may be electronically communicating with me from either VHA electronic devices or from their own personal electronic devices.
- I understand that VHA will not record any part of my virtual care session without obtaining specific further consent.
- I understand that, in the event I require first aid or any other direct care during a virtual session, VHA will not be able to provide that to me and will be limited to calling 9-1-1.

Nevertheless, I hereby request and consent for VHA service provider(s) to electronically communicate, provide virtual care, and share personal health information with:

<input type="checkbox"/>	Me, and/or my substitute decision maker, using the electronic platforms of: Microsoft Teams or Ontario Telemedicine Network (OTN) and sending emails to me at: _____ <div style="text-align: right; margin-right: 50px;"><i>(email address)</i></div>
--------------------------	--

Having read and understood the above statements, discussed the risks and benefits of proceeding with my VHA health care provider and having had an opportunity to have my questions answered, I consent to VHA communicating with me and/or my substitute decision maker, in respect of my personal health information, and providing virtual care using the electronic/audio visual/virtual communication software/application/email noted above.

I understand that I may withdraw my consent at any time.

<i>Name of Client/ Substitute Decision Maker</i>	<i>Signature of Client/ Substitute Decision Maker</i>	<i>Date (MM/DD/YYYY)</i>

VHA RECOMMENDATIONS FOR VIRTUAL CARE:

- 1. Always use a secure, private internet connection (e.g., avoid free/public Wi-Fi).**
- 2. Consider the setting and ensure others cannot listen in or view without your consent.**
- 3. Engage your back-up plan in the event of technical difficulty/failure.**