RECOMMANDATIONS AND CONSENT TO TELECONSULTATION (TELEHEALTH)

Teleconsultation is a form of virtual care (telehealth) that enables patients to consult their healthcare professional remotely, via video call.

Personal information

Your personal information is handled with the same level of **security** and **confidentiality** during telehealth sessions as it is during in-person visits, in accordance with your rights.

For more information about your rights, click here:

YOUR RIGHTS
(French only)

Confidentiality

To enhance confidentiality, please ensure you are in a **quiet and private location**, preferably a closed room. If needed, you may also use headphones with a microphone.

Recording

The teleconsultation **will not be recorded**, and its content will not be used for any other purpose.

You are expected not to record the teleconsultation or take screenshots of the session without first informing your healthcare professional.

Consent

You may **withdraw** your consent at any time by notifying us. We will then inform you of available alternatives, such as an in-person or phone consultation, based on your healthcare professional's recommendation.

ICM, septembre 2025

INSTITUT DE CARDIOLOGIE DE MONTRÉAL

CONSENT TO VIRTUAL CARE

(TELEHEALTH)

Text from the virtual care consent form that was read or presented to you when your appointment was scheduled.

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.