

CONSENT TO PATIENT AUDIO RECORDING

Healthcare providers today spend a significant amount of time documenting patient care. To support our mission of providing high quality care, we are now employing technology which uses artificial intelligence to record audio (not video) of patient visits. This technology significantly reduces the amount of time your provider spends on documentation and allows more time for him/her to provide direct patient care to you. The technology uses a third-party service provider to process the recorded audio. All documentation is reviewed, edited and approved by your provider to ensure the accuracy and completeness of your medical record.

We ask you to sign this form to indicate your consent to have your visit(s) recorded and processed in this manner for the purpose of documenting your care.

CONSENT

I understand that patient care services will be recorded only by the provider treating me unless I have expressly consented and signed a release of information for others to record my visit, or unless another exception to confidentiality applies. Such recordings may include protected health information covered under HIPAA.

I further understand that if I request that a family member, friend or other third party ("Approved Third Party") be present in the room where my visit is being recorded, it also will be necessary to obtain the consent of the Approved Third Party. I understand that recording my visit is not a requirement for me to receive treatment from my provider.

My agreement and participation in recording my visits are knowing and voluntary. Further, understand that I may withdraw my consent for recording visits or ask questions about my recordings at any time. I acknowledge that I have been provided with a HIPAA Notice of Privacy Practices by the practice.

I understand that my consent is voluntary, and my care will not be conditioned on providing consent.

I hereby consent to the recording of my visit today as well as any future visits. I understand that I may revoke my consent to the recording of future visits at any time.

☐ Yes

☐ No

Signature of patient or legal
representative

Date: