

Updated: July 14, 2021

## Rochester RHIO Telehealth Verbal Consent Procedure

**IMPORTANT:** The procedure MUST be followed by authorized users exactly. Of course, providers should be taking proper precautions to validate patient identity. Telehealth consent is NOT durable. The telehealth consent option stays in effect for a 72-hour period. Telehealth consent also excludes specialty protected sensitive health data like SAMHSA. Users looking at patient records in Explore+ will not have access to Part 2/SAMHSA data.

### For Explore+ Authorized Users:

#### Telehealth Verbal Consent Procedure

1. Access Explore+ as normal.
2. Before searching for a patient, click the reason that matches purpose of your search. (Example: Treatment)
3. Then, search for the patient as you normally would.
4. Once patient search is complete, a Patient Card displays. Click on the patient card to record telehealth consent for one-time, 72-hour access.  
**Important: DO NOT** click on the editing pencil for telehealth verbal consent. The editing pencil is for durable, written consent only.
5. Click “Telehealth Verbal Consent” to record non-durable, verbal consent.

You Cannot Access This Patient's Data.

Jane Rochester | 05/15/1938 | 82 yrs | Female | Community ID: 777779050 |  
123 Maple Street Rochester, NY, 14623

Consent In Effect: **Unknown**

Consent Choice Management

Patients have the ability to grant or deny access to their information through Rochester RHIO. To change this patient's consent status, a new consent form must be signed and retained. Click the "Record Consent" button to add or change consent for this patient.

Access to this patient's data is subject to audit.

Telehealth Verbal Consent

New York's State of Emergency allows for informed verbal consent prior to, or during a telehealth visit. For patients without prior written consent, verbal consent is allowed. This consent should be granted during each visit and is not considered durable.

Access to this patient's data will be audited.

6. Telehealth consent should be documented in the patient's chart and attached to the patient's encounter. This documentation may be requested at a later date during an audit.

*This procedure was initially created in response to the COVID-19 Pandemic and was allowed by the New York State Department of Health under the former public health emergency. This procedure has been updated and approved through NY State Policy for continued use after the Executive Order ended.*