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## All Campers: Atrium Health Waiver

For:

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### Atrium Health Virtual Care

Atrium Health Virtual Care (AHVC) is available to all campers at this location. By completing this form, you are acknowledging that you understand the risks and benefits of your child receiving treatment and you give Atrium Health consent to treat your child this way. AHVC is the use of electronic information and communication technologies by a healthcare provider to deliver services to your child when the provider is located at a different place. Not every condition can be treated by virtual care. If your child's treatment provider believes your child would be better serviced by in-person treatment you will be notified and referred to an in-person setting for further care. Your child's care team will decide if more treatment is needed at the hospital.

Virtual Care encounters are still subject to the requirements of the HIPAA Privacy Rule that apply to Protected Health Information. If you text or email Atrium Health with patient information in an unsecured manner, you understand the risks of doing so and give Atrium Health permission to respond to you in a similar, unsecured manner.

There is the risk that treatment provided by Virtual Care could be disrupted due to technical failure.

### Release of Information

In treating your child with AHVC, his/her information will be used and shared to provide care or conduct healthcare operations. For example, Atrium Health may use your child's information to coordinate care with other providers; they may share information with personnel about how to administer medications or accommodate your child's condition; they may use the information to evaluate how the services were delivered and health situation. Atrium Health may also receive information from other providers and pharmacies, such your child's health history and medication list. Atrium will keep a copy of this information in your child's medical record. In addition, Atrium Health may release your child's medical information, including information regarding communicable diseases, and any clinical, lab and radiology reports, to camp representatives and the local health department for safety reasons or as necessary to provide medical care and treatment to your child and to coordinate care.

By participating in AHVC, you give permission for Virtual Care to share information as described above.

### Privacy

All persons have health issues that must be handled in a confidential manner. Staff will share confidential information only when necessary to address potential health care needs, to ensure the safety of the patient, other children, and staff, or other situations specified by law. By participating in AHVC, you give permission for designated camp personnel to share information with AHVC clinics and its providers, about your child's health history if appropriate, and/or other emerging health concerns, included but not limited to information related to communicable diseases, evaluation for ADD/ADHD, development concerns such as speech delays, medications, results of physical examinations, consults and diagnostic results or other clinical, behavioral, developmental or related reports and records, and any other information pertinent to the coordination of care for your child.

### Insurance

Many insurance plans are covering virtual care services at this time. You understand that by participating in AHVC program, Atrium Health may contact your insurance carrier to determine eligibility for payment and will bill your health insurer for covered services. You understand that you may be responsible for copays and deductibles

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related to these services. If your insurance does not cover Virtual Care services you will be responsible for the full cost of the services you receive.

Consent for Services

I, the parent/guardian, give consent for my child to receive services from Virtual Care as described in this document. I understand that this Consent Form will be good until my child leaves camp or until I provide the Virtual Care staff with written directions otherwise. I understand that this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this consent prior to the revocation. Any request for revocation must be in writing.

By signing below, I agree as legal custodian of my child that I have read, accepted and agreed to be bound by this consent, notice and acknowledgement in relation to the services, including Virtual Care services, provided to my child. I understand that if I do not sign this document, my child will not be able to receive treatment as a part of the program.

Signature \_\_\_\_\_ Date \_\_\_\_\_