aTouchAway™

JOSEPH BRANT HOSPITAL

Remote Patient Support Consent Form

I, (patient name)_____, (date of birth)_____, wish to participate in the Remote Patient Support pilot program being offered by Joseph Brant Hospital (JBH) to support patient transitions from hospital to home through the use of a digital application called aTouchAway, provided by Aetonix Systems Inc. (Aetonix). The aTouchAway application will be used to support my coordinated care plan following discharge and allow me to connect to my healthcare professionals once I have been discharged home. I understand that the aTouchAway program is being provided to me at no cost, and as a supplemental support for me in my home.

1. I authorize JBH and the non-healthcare members involved with the coordinated care plan (listed below) to collect, use and disclose relevant personal health information with one another using the aTouchAway solution for the purpose of supporting the coordinated care plan and connecting providers to improve care. This may include sharing of information about past medical history, Emergency Room visits and hospital admissions.
2. As part of the pilot program, I may receive the loan of the devices/equipment necessary to support this pilot program or I may choose to use my own personal device. I understand that any equipment issued to me belongs to JBH and I am responsible to maintain this equipment in good condition while it is in my possession, and in accordance with JBH's Loan of Equipment Contract. I acknowledge that participation in the pilot program requires cellular connectivity and JBH is not responsible for any data usage or other costs.
3. I acknowledge that the aTouchAway program is not a substitute for medical assessment and care.
4. In the event medical assistance is required, I acknowledge that it is my responsibility to take the necessary actions to obtain the care required.
5. I acknowledge that I have received the program materials and have had the opportunity to discuss this pilot program with a health care provider who has reviewed the potential risks and benefits of participating in the program with me. I have been provided an opportunity to ask questions related to the program.
6. I understand that my decision to participate in this pilot program is completely voluntary. I also understand that I am free to withdraw my participation at any time and it will not affect the quality of care received or my ability to access care.
7. I understand that the JBH care team will support the program after my discharge from hospital as outlined in the coordinated care plan and the pilot program materials provided.
8. I confirm that I will be asked to complete surveys throughout the pilot program to assess impacts related to quality of care and patient experience. I understand these surveys are voluntary and completing them is not a mandatory requirement for participation.
9. I have read and acknowledge the pilot program materials, including appropriate communications with my health care provider as they pertain to the use of personal health information, hours of service, phone and video communication. I understand that the program involves the communication of sensitive personal health information electronically and in real time. Though the data in the application is encrypted, any use of technology may introduce risk.

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Please note that this program is not a replacement for urgent or emergent medical care. If you feel your health is at risk, please call 911 and go to the closest hospital emergency department.

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Consent to Share Personal Health Information

I provide my consent for the following non-healthcare members to collect, use, or disclose personal health information about me and to participate in my care through the aTouchAway pilot program.

Participant's email:_____

Name of Non-healthcare members allowed to participate through or aTouchAway (i.e. Family, community caregivers, neighbors, etc.)	**Contact Information** (email)	**Consent Given** (Pt initial)

I have reviewed this aTouchAway Consent Form and program documents and hereby provide my consent to participate in the aTouchAway pilot program for myself, or on behalf of the stated patient, as legal substitute decision maker.

_____ _____ _____ /_____/ _____
Signature of Participant Name (Printed) YYYY MM DD

_____ _____ _____ /_____/ _____
Signature of Participant Name (Printed) YYYY MM DD

_____ _____ _____ /_____/ _____
Signature of Participant Name (Printed) YYYY MM DD

***Note: A copy of this form will be provided upon request.**

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