

## CONSENT FOR VIDEO VISIT OF A MINOR PATIENT

I voluntarily consent to medical examination and treatment of my child by OhioHealth practitioners through the use of video-conferencing technology ("Video Visit"). I understand that, during a Video Visit, the treating practitioner may request my specific consent for my child to fully or partially undress. I understand that my child will be asked to undress only for a bona fide medical purpose in the professional judgment of the treating practitioner. I further understand that it may be necessary for the treating practitioner to request me to take one or more screen shots or pictures of my child during a Video Visit and submit securely through MyChart to be uploaded directly into the OhioHealth's EMR. I understand that I may agree to or deny such requests and may choose to end the visit at any time for any reason.

I further acknowledge that I have chosen to seek care for my child through this Video Visit, and I have therefore chosen to provide an electronic signature on this consent form rather than a written signature.

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

MRN: \_\_\_\_\_

\_\_\_\_\_

Signature of Parent or Guardian

\_\_\_\_\_

Signature of Additional Witness