CONSENT TO USE OF AI SCRIBE

Patient Name: _____ Date of Birth: _____

Purpose of AI Scribe:

Hoag utilizes AI scribe technology to create notes in real-time, allowing your providers to focus on you, the patient, and less on documenting the encounter itself. The AI scribe tool creates a temporary recording of the conversation to generate a draft note. Once finalized, the note will become part of your medical record. The recording will be destroyed after the note is finalized; no recording will be maintained by Hoag or used by anyone outside of Hoag.

Privacy & Security:

Your privacy is our utmost priority. The AI scribe tool adheres strictly to all State and Federal laws, including HIPAA guidelines, to ensure that your protected health information is secure and protected. In addition, the recording is made consistent with California Penal Code Section 632, which requires the consent of all parties to a confidential communication before it can be legally recorded.

Your Rights:

Your participation is completely voluntary. Your consent and participation may be withdrawn at any time without affecting the quality of your care.

Consent:

I acknowledge that I have read and understand the information provided above, and I consent to the audio recording of my conversations for the purpose of maintaining accurate medical records. I further acknowledge that I have been informed that this recording is being made in accordance with California Penal Code Section 632, which requires the consent of all parties to a confidential communication before it can be legally recorded. I understand that I will not have access to the resulting recording, only the resulting note once signed off on by the provider and transferred to my electronic medical record.

I consent to the use of the AI scribe tool as detailed above. This consent is effective unless withdrawn.

Patient/Legal Representative Signature:_____Date: _____ Time: _____
(If under 18 years of age, signature of parent or legal guardian)

If signed by other than patient, indicate relationship:_____

Print Name (Legal Representative): _____

Witness Signature: _____ Date: _____ Time: _____

If you would like to withdraw your consent and not permit future recordings using the AI scribe tool, please contact Hoag Medical Records:

- MAIL: Hoag Memorial Hospital Presbyterian
  Attn: Medical Records/Release of Information
  One Hoag Drive
  Newport Beach, CA 92658
- FAX: Medical Records/Release of Information
  949-764-8237
- EMAIL: HoagMedicalRecords@hoag.org