**Consent Form for Use of AI Scribe Program in Medical Records**

**Purpose:**  
This consent form is to obtain your authorization for the use of an AI-powered scribe program to assist in the documentation and management of your medical records. The AI scribe could be used by Dr. Wright in this office to accurately and efficiently record your medical information during consultations and treatments.

**What is an AI Scribe?**  
An AI scribe is a computer program that uses artificial intelligence to transcribe, document, and manage medical information. It is designed to assist healthcare providers by automatically capturing and recording details of your visit, including medical history, treatment plans, and recommendations, into your electronic medical record (EMR).

**How It Works:**

* During your visit, the AI scribe will listen to and analyze conversations between you and your healthcare provider.
* The AI scribe will generate notes and update your medical records in real-time under the supervision of your provider.
* Your healthcare provider will review and approve all notes generated by the AI scribe to ensure accuracy and completeness.

**Consent for Use of AI Scribe Program**

1. **Authorization**
   * I authorize the use of the AI scribe program during my medical visits to assist in the documentation of my medical records.
   * I understand that the AI scribe will only be used for the purpose of recording and managing my medical information and that the final record will be reviewed and approved by my healthcare provider.
2. **Confidentiality and Privacy**
   * I understand that my medical information is protected under the Public Health Insurance Portability and Accountability Act (PHIPAA) and that the AI scribe program is compliant with all privacy and security regulations.
   * I acknowledge that reasonable measures are in place to protect my personal health information from unauthorized access or disclosure.
3. **Accuracy of Information**
   * I understand that while the AI scribe program is designed to be accurate, my healthcare provider will review and correct any errors in the documentation to ensure the accuracy of my medical record.
   * I acknowledge that I can review my medical records at any time and request corrections if necessary.
4. **Opting Out**
   * I understand that my participation in the use of the AI scribe is voluntary, and I may withdraw my consent at any time by notifying my healthcare provider.
   * If I choose to opt out, my provider will continue to document my medical record without the use of the AI scribe.
5. **No Impact on Care**
   * I acknowledge that the use of the AI scribe will not affect the quality of care I receive and that my provider remains fully responsible for my medical treatment and decision-making.

**Acknowledgment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient name) have read and understand the information provided above regarding the use of an AI scribe program for medical record documentation. I give my informed consent for the use of the AI scribe during my medical visits.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_