ClinicalConnect™ Hamilton Health Sciences | HITS eHealth OFFICE

ClinicalConnect Testimonial/Quote Request Form

Thank you for considering the opportunity to provide a testimonial/quote speaking to the benefits you've realized when using ClinicalConnect in your healthcare delivery to patients. Based on your responses, the ClinicalConnect Program Office will leverage direct quotes you provide, or may prepare a summary testimonial that incorporates your responses. If the latter, we'll email you the testimonial content for your approval prior to publication. Thank you.

Please respond to the questions below and complete the Consent Form that follows, then click SUBMIT. ***Please do not include any Personal Health Information (PHI) or personal patient identifiers in your responses.***

Your Full Name:	
Your Job Title:	
Your Organization Name:	
Today's Date:	

Please describe how you most often use ClinicalConnect as part of your healthcare delivery. Please include *how* you access the portal most often (i.e. on a desktop device, or mobile device while you're on the go?)

Since you started using ClinicalConnect, what specific workflow or operational challenges have you been able to overcome or resolve?

What do you feel are the top three benefits of using ClinicalConnect?

Specifically, what is the best thing about ClinicalConnect in your opinion?

What would you tell a colleague who's considering integrating ClinicalConnect into their clinical workflow?

Is there anything else you'd like to add?

Do you have a patient(s) who is aware of how you've used ClinicalConnect to provide healthcare to them, who might be willing to provide a testimonial/quote noting the benefits from their perspective?

☐ Yes I do, and please contact me so I can connect you with them.
☐ No, I do not.

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Consent for Photography, Video/Audio Taping, Televising, Interviewing & Internet Imaging

You are being asked for your consent to one or more of the following:
- Have your photograph taken;
- Be videotaped;
- Have your voice recorded; and/or,
- Be interviewed for your personal story.

You may refuse to give your consent. This will not affect your treatment, employment, and/or affiliation with Hamilton Health Sciences in any way.

Consent

I *(type/print name)* ____ give permission to

- Hamilton Health Sciences Corporation (King West, Hamilton General Hospital, Juravinski Hospital and Cancer Centre, McMaster Children's Hospital, McMaster University Medical Centre, West Lincoln Memorial Hospital, Urgent Care Centre, Ron Joyce Children's Health Centre, and affiliated charitable Foundations),
- The HITS eHealth Office at Hamilton Health Sciences Corporation

or

- any persons authorized by Hamilton Health Sciences Corporation (hereinafter "HHS"), to take and produce photographs, films, sound recordings and any other audio and/or visual reproductions of myself,

to take or collect and use my photograph, video image, voice recording, and/or personal interview for possible use in:

- HHS' materials such as videos, publications, posters, intranet site and/or websites including HHS' official social media sites (ie. Facebook)
- external media such as websites, newspapers, TV programs and/or radio programs.
- Ontario Health (Digital Services)(funder of ClinicalConnect™, a web-based portal operated by HHS) materials such as videos, Benefits Realization case studies, publications, posters, and/or websites including official social media sites (ie. LinkedIn, Twitter)
- communications collateral developed to support the awareness and deployment of a patient portal, and,

  My name and title may be used

  My name and title may not be used

I understand that pictures/images on the HHS-affiliated websites can be downloaded by external users for their personal use and that HHS shall not be held responsible for such use.

I understand that this image, recording or information may be maintained and used in the HHS Archives, as well as in media archives, and I consent to such use.

I further agree that HHS may use, publish and otherwise deal with images, recordings or information as they see fit.

Signature: ________________________________

Date: ___________________________________

Once complete, click Submit. Option to sign this form with a Digital ID/Signature may not be available depending on your version of Adobe. If required, please email completed Consent Form to support@clinicalconnect.ca.