Informed Consent for Telemedicine Services

PATIENT NAME: _____

DATE OF BIRTH: _____

Purpose
The purpose of this form is to obtain your consent for a telemedicine consultation with your primary care provider/team.

Introduction
Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider(s) and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Risks, Benefits and Alternatives
The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of your home or local health care community. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a physician.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information.

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4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My primary care provider has explained the alternatives to my satisfaction.

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that it is my duty to inform my primary care provider of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my primary care provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____ (name of primary care provider) to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient):

_____

Date:

_____

If authorized signer, relationship to patient: _____

I have been offered a copy of this consent form (patient's initials) _____