Informed Consent for Telemedicine Services

Patient Name: ____________________________________DOB: _________

About Telemedicine:

Telemedicine involves the use of electronic communication technologies by a health care provider to deliver healthcare services to a patient when the patient and provider are at different locations.

I understand the following:

- Telemedicine visits are not recorded, and video, audio, or images are not electronically stored.
- Laws that protect privacy and confidentiality of medical information also apply to telemedicine.
- The doctor may bill my healthcare insurance for telemedicine services, and I will be responsible for any copayments or co-insurances that apply to my telemedicine visit.
- I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by advising my doctor. If I do not revoke my consent, my doctor may provide healthcare services to me via telemedicine without the need to sign a consent for each telemedicine encounter.

Benefits: Potential benefits of telemedicine include improved access to medical care by enabling a patient to remain at home or a site remote from the physician office.

Risks: I understand that there are potential risks associated with the use of technology for telemedicine services, including but not limited to:

- The video connection may not work or may stop working during the telemedicine visit.
- The video or sound may not be clear enough to be useful to effectively complete the telemedicine visit.
- I may need to reschedule an in-person visit if the doctor believes the information able to be obtained during the telemedicine visit is insufficient.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Security protocols could fail, causing a breach of privacy of personal medical information.

I understand that electronic systems used will incorporate security protocols, in accordance with Federal law, to protect the confidentiality of patient identification and information and will include measures to safeguard against electronic interception of the communication, however no guarantees have been provided.

Certification of Patient

By signing below, I certify that I have been instructed on accessing telemedicine services and have had an opportunity to ask the doctor all my questions concerning anticipated benefits, and potential risks, and all of my questions have been answered to my satisfaction. I hereby consent to having my doctor provide health care services to me via telemedicine and accept any associated risks.

______________________________________ ______________________

Patient Signature or Authorized Individual Date

______________________________________ ______________________

Print Name of Authorized Individual Role of Authorized Individual