Informed Consent for Telemedicine Services

PATIENT NAME: _____	DATE OF BIRTH:	MEDICAL RECORD #:
LOCATION OF PATIENT: _____	_____	_____

CLINICIAN NAME: _____	LOCATION: _____	DATE CONSENT
CONSULTANT NAME: _____	LOCATION: _____	DISCUSSED:
CONSULTANT NAME: _____	LOCATION: _____	_____

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care clinicians, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

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.

Responsibility for patient care remains with the patient's local clinician, as does the patient's medical record.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in a local health care setting.
- More efficient medical evaluation and management.
- Obtaining the expertise of a specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to, the following:

- In rare cases, the consultant may judge that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient.
- Delays in medical evaluation and treatment could occur due to limitations or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Please initial here after reading this page: _____

By signing this form, I indicate that 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 patient identifiable information obtained in the use of telemedicine 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 for a reasonable fee.

4. I understand the alternatives to telemedicine consultation as they have been explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

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

6. 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.

7. I understand that individuals other than my health care provider and consulting health care provider may be present and that they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my clinician 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 clinician)* 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:*_____

*Witness:*_____ *Date:*_____

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