Patient Authorization and Informed Consent to Participate in Telemedicine

Patient Name:
Patient Physical Location:

- Telemedicine applies videoconferencing technology to facilitate healthcare delivery enabling distant site physicians to provide virtual healthcare services for patients at another location. Telemedicine information may be used for diagnosis, therapy, follow-up and/or education, and may include, but is not limited to the following: (1) medical records; (2) medical images (i.e., x-rays, etc.); (3) live two-way audio & video; (4) data from medical devices & sound & video files.
- Telemedicine will use network and software security to protect patient confidentiality and safeguard data.
- Responsibility for patient care and the medical record remains with the patient's local, treating clinician.

Expected Benefits: (1) Improved access to medical care by enabling a patient to remain in a local health care setting; (2) More efficient medical evaluation and management; and, (3) Obtaining the expertise of a specialist.

Possible Risks include, but are not limited to: (1) The Distant Site Physician might decide the transmitted information is inadequate, requiring a face-to-face consultation; (2) Delays in treatment due to limitations &/or failures of the equipment; (3) Security protocols might fail, causing a breach of confidentiality &/or privacy of protected health information

I UNDERSTAND THE FOLLOWING: (1) Laws that protect privacy and confidentiality of medical information also apply to telemedicine; (2) Patient identifiable information will not be disclosed to researchers or other entities without my consent; (3) I have the right to withhold or withdraw my consent to the use of telemedicine at any time, without affecting my right to future care or treatment; (4) I have the right to inspect information obtained and recorded during a telemedicine interaction and may receive copies of this information for a reasonable fee; (5) Alternatives to telemedicine consultation have been explained to me; (6) Some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the Distant Site Physician; (7) Telemedicine may involve electronic communication of my protected health information to other medical practitioners involved in my care who may be located in other areas, including out of state; ; (8) There are limitations of telemedicine, and the Distant Site Physician cannot examine me in-person, and an in-person examination would be ideal; (9) Results cannot be guaranteed or assured (10) Individuals other than my health care provider and consulting health care provider might be present; they will maintain confidentiality of the information obtained, and I will be informed of their presence.

Patient Consent to The Use of Telemedicine
I understand the information above regarding telemedicine, & have discussed it with my clinician, and all of my questions have been answered to my satisfaction. I consent to the use of telemedicine in my medical care.

I AGREE TO THE USE OF TELEMEDICINE. Sign and date below if you agree.

Patient/Authorized Representative Signature ______ Date/Time ______ Patient/Authorized Representative Printed Name ______

Relationship to Patient ______

Witness Signature ______ Date/Time ______ Witness Printed Name ______

Interpreter Signature ______ Date/Time ______ Interpreter Printed Name ______

I have been offered a copy of this Consent Form (Patient's Initials): ____________

Patient Label