Informed Consent for Telemedicine Services

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

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

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical/dental 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 healthcare 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.

Expected Benefits:

- Improved access to medical/dental care by enabling a patient to remain in his/her clinician's office (or at a remote site) while the clinician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient healthcare evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any healthcare procedure, there are potential risks associated with the use of tele-medicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in evaluation and treatment could occur due to deficiencies 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 treatment records may result in adverse drug interactions or allergic reactions or other judgment errors;

Please initial after reading this page: _____

By signing this form, I understand the following:

1. I understand the laws that protect privacy and the confidentiality of healthcare 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 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 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 a variety of alternative methods of healthcare may be available to me, and that I may choose one or more of these at any time. My clinician has explained the alternatives to my satisfaction.
5. I understand telemedicine may involve electronic communication of my personal healthcare information to other healthcare practitioners who may be located in other areas, including out of state.
6. I understand it is my duty to inform my clinician of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand I may expect the anticipated benefits from the use of telemedicine in my care, but 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 clinician 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 healthcare.

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) _____