Patient Consent to Telemedicine Services

PLEASE READ EACH SECTION CAREFULLY. YOU MAY REQUEST A COPY OF THIS FORM FOR YOUR OWN RECORDS.

Introduction: Telemedicine involves the real-time evaluation, diagnosis, consultation on and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real time. There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand I can ask questions and seek clarification of the procedures and telemedicine technology at any time.

I. **Consent for treatment:** I voluntarily request [Practice/Provider Name] and its physicians, nurses, associates, technical assistants and other health care providers as it may deem necessary (collectively "**Practice**") to participate in my medical care through the use of telemedicine.

I understand that Practice (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I further acknowledge my failure to accurately and completely relay information about my medical history, condition and care may adversely impact Practice's advice, recommendations or decisions about my care. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

I understand that if Practice determines in its reasonable professional judgment that telemedicine services will not adequately address my medical needs, I may be required to complete an in-person medical evaluation. I also understand that in the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented, or an in-person medical evaluation may be necessary. Finally, if I experience an urgent matter after a telemedicine session, such as a bad reaction to a treatment, I should alert my treating physician and, in the case of emergencies, dial 911 or go to the nearest hospital emergency department.

II. **Release of information:** To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of my Personal Information (defined below) to Practice. I understand this disclosure may include my name, address, contact and demographic information, general health status and treatment information, images, individually identifiable health

information or protected health information, and other information related to my health or condition (collectively "**Personal Information**").

I understand that the disclosure of my Personal Information to Practice, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

III. **Right to withdraw consent:** I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time.

I have read this Telemedicine Consent in its entirety and agree to be bound by all of its terms and conditions as described above. I acknowledge and agree that I have been given the opportunity to ask any questions and have either (i) declined the opportunity to do so, or (ii) had all my questions answered to my satisfaction.

Printed Patient Name	**Signature of Patient/Personal Representative**
Relationship to Patient	**Date**
Practice Representative Name	**Signature of Practice Representative/Witness**