Telemedicine Informed Consent

Patient Name: _____ Date of Birth: _____

Location of Patient: _____

Introduction

Telemedicine is a form of service that allows patients to access health care and health education services using audio-video interface such as video conferencing.

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 health care and health education services.
- Improved patient engagement.
- More efficient evaluation and care plan management.

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:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider
- Delays in medical 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 medical records may result in adverse drug interactions or allergic reactions or other judgmental errors;

Please initial after reading this page: _____

By signing this form, 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 information obtained in the use of Telemedicine which identifies me 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 in the course of a Telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of heath care and health education services may be available to me, and that I may choose one or more of these at any time.
5. I understand that it is my duty to inform my health professional of any other healthcare providers involved in my medical care.
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 agree that certain situations including emergencies are inappropriate for telehealth services. If I am in a crisis or emergency, I agree to call 911 or go to the nearest hospital or crisis facility. By signing this document, I acknowledge that I have been told that if I feel suicidal, I should call 911, local county crisis agencies, or the National Suicide Hotline at 1-800-784-2433

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding Telemedicine, have discussed it with my health care 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 Community Health Service Inc. 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) _____