TeleHealth Consent **(Version 1, Date: 03.15.20)**

Patient Name: _____ Date of Birth: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential benefits to this technology including:
    - Improved access to medical care by enabling a patient to remain in his/her/their home or at a remote site and more efficient medical evaluation and management.
4. I understand there are potential risks to this technology, including:
    - In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the health care 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 judgment errors
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
6. I have had the alternatives to a telemedicine consultation explained to me and am choosing to participate in a telemedicine consultation.

By signing this form, I certify:

1. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
2. 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.
3. 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.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.

_____ _____

Patient's/parent/guardian signature Date

_____

Patient's/parent/guardian printed name