Consent for Telemedicine Services

Patient Name: Date of Birth:

Introduction

Telemedicine is the delivery of healthcare services when the healthcare provider and patient are not in the same physical location through the use of technology. Providers may include primary care practitioners, specialists, and/or subspecialists. Electronically-transmitted information may be used for diagnosis, therapy, follow-up and/or patient education, and may include any of the following:

- Patient medical records
- Medical images
- Interactive audio, video, and/or data communications.
- Output data from medical devices and sound and video files.

The interactive 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.

Potential benefits include, but are not limited to: Improved access to medical care by enabling a patient to remain in his/her physicians's office (or at a remote site) while the physician obtains test results and consults with healthcare practitioners at distant/other sites; and obtaining the expertise of a distant specialist.

By signing this form, I understand and agree to the following:

1. The laws that protect the privacy and confidentiality of medical information also apply to telemedicine. No information obtained during a telemedicine encounter that identifies me will be disclosed to researchers or other entities without my consent.
2. I have the right to withhold or withdraw my consent to the use of telemedicine during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment, nor will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled.
3. I have the right to inspect all information obtained and recorded during the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. A variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time. My physician has explained the alternative care methods to my satisfaction.
5. Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out-of-state.
6. I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. My condition may not be cured or improved, and in some cases, may get worse.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician 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 consent to and authorize Integrative Family Medicine to use telemedicine in the course of my diagnosis and treatment.

Name:

Relation to Patient (if signed by legal representative): Date: MM/DD/Y

Witness Name, if applicable: Date: MM/DD/Y

Patient or patient's representative, and witness, if applicable, please sign with mouse or finger:

Clear Signature