Informed Consent for Telehealth Services

PATIENT NAME: _____ LOCATION OF PATIENT: _____	DATE OF BIRTH: _____	MEDICAL RECORD #: _____
PHYSICIAN NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____		DATE CONSENT DISCUSSED: _____

Telehealth, which includes telemedicine, involves the use of electronic information and communications to enable health care providers at different locations to deliver health care services to an individual when he/she is located at a different site than the provider. The services shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient.

I understand that telehealth services are being delivered, and hereby consent to **[name of provider]** providing care services to me via telehealth.

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 care by enabling a patient to remain in or at a remote site while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

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 physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the technology;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- The provider cannot guarantee that the encounter is confidential, as a person on the patient's end may be able to overhear conversations related to the patient's care;
- There are limitations to using telehealth for the patient's care as it does not involve a hands-on examination. For example, the encounter may result in a need for the patient to come to the office or another facility for further treatment: a patient-to-provider "hands-on" assessment, a procedure, a test, etc., and the patient must be willing to cooperate with that need should it be identified.

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 and recorded 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 medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. 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.

Patient Consent To The Use of Telehealth

I have read and understand the information provided above regarding telehealth/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 authorize ***(name of provider)*** 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) _____