Telemedicine Consent Form

Patient Name: _____ Date of Birth _____

1. I understand that my health care provider is offering a telemedicine visit as an alternative to an in-person visit.
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 risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
5. I understand 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 will inform my health care provider if any other people are present on my end during the telemedicine visit.
7. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to these visits. 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.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of this type of visit.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient Signature _____ Date _____

(Patient must be 18 years old or parent/guardian must sign)

FOR CLINIC USE ONLY:

Witness Signature _____ Witness Name (printed) _____

Check if consent given verbally: ☐