



INFORMED CONSENT FOR TELEMEDICINE/VIRTUAL COMMUNICATION SERVICES

Telemedicine involves the use of electronic communications to enable health Care providers at different locations to assist in the evaluation, diagnosis, management, and treatment of a number of health care problems. Providers may include primary care practitioners, specialists, and/or subspecialists.

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.

[The type of service to be provided by telehealth/virtual communication is:](#)

- Behavioral Health Counseling
- Medical Services

[By signing this form, I understand the following:](#)

1. The consulting health care provider or specialist will be at a different location from me. A health care provider or other health care professional may be present with me in the room to assist in the consultation.
2. I acknowledge that I have the right to request the following:
 - Omission of specific details of my/the patients medical history/physical examination that are personally sensitive.
 - Asking non-medical personnel to leave the room at time of service if not mandated for safety concerns.
 - Termination of the service/session at any time.
3. The presenting health care provider or professional health care staff may transmit or share electronically details of my medical history, examinations, x-rays, tests, photographs or other images with the provider who is at a different location.
4. 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 that identifies me will be disclosed to researchers or other entities without my consent.
5. I understand that I have the right to 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.
6. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
7. A record of the consultation will be kept in my medical record.

8. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
9. 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.

I have read and fully understand the information provided above regarding telemedicine. I hereby give my informed consent for the use of telemedicine in my health care.

Patient Signature _____ Date: _____

Patient Name Print: _____

Guardian Signature (if applicable): _____ Date: _____

Guardian Name Print: _____

Relationship to Patient: _____

Email: _____

Witness 1: _____ Date: _____

Interpreter (if required): _____ Date: _____