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Informed Consent for Telemedicine Services

Introduction

Telemedicine involves the use of electronic communications to enable health care providers and patients at different locations to have a medical consultation. Your provider will use a variety of information for diagnosis, therapy, follow-up and/or education, and may include any of the following:

· Patient medical records
· Medical images
· Live two-way audio and video
· Output data from medical devices and sound & video files

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.

Examples of office visits that may qualify for telemedicine: medication follow up visits (for hypertension, depression, anxiety, diabetes etc), lab reviews, counseling visits, skin concerns.

Expected Benefits:

· Improved access to medical care by enabling a patient to remain in his/her home or other location
· More efficient medical evaluation and management.

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 equipment;

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.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners
6. 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 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 authorize Dean Chier, MD to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient):_____Date: _____