INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name:	Date of Birth:
Date Consent Discussed:	
Physician Name: Carey McNamara PA-C	Location: Whole Heart Family Medicine

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used 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 and 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.

EXPECTED BENEFITS

- Improved access to medical care
- 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.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- Telemedicine examinations or care may not be as complete as face-to-face examinations or care.

Please initial after reading this page: _____

BY SIGNING THIS FORM, I ATTEST TO AND 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 during 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 during the telemedicine interaction and may receive copies of this information for a reasonable fee.
4. 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.
5. I understand I am responsible for my co-pay or co-insurance just like an in-office appointment.
6. I understand some medical conditions require a physical exam and warrant a direct evaluation, so I agree to come in for a separate in-office appointment if deemed necessary.

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 Carey McNamara PA-C (*name of Provider*) to use telemedicine in the course of my diagnosis and treatment.

_____ _____

PATIENT'S SIGNATURE **DATE**
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

_____

IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT

_____ _____

WITNESS **DATE**

I have been offered a copy of this consent form. _____ (Patient's Initials)