STONE CREEK PSYCHIATRY

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INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name:_____Date of Birth:_____

Provider Name:_____Location:_____

Telemedicine involves the use of electronic communications to enable healthcare 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. Information may be used for diagnosis, therapy, follow up and/or education, and may include any of the following: Patient medical records, medical imaging, live two-way audio and video, output date from medical services and sound and video files. Electronic systems used will incorporate network and software security protocols to protect confidentiality of patient identification and imaging data will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

Promoting the safety and protection of patients and staff from obtaining and/or spreading Covid-19. Improve access to medical care by enabling the patient and provider to interact from distant locations. More efficient medical evaluation and management. Obtaining expertise of a distance specialist.

Possible Risks:

As with any medical procedure, there ae 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 (poor resolution of images or sound) to allow for appropriate medical decision-making by the provider. Delays in medical evaluation and treatment could occure due to the deficiencies or failures of the equipment. In very rare instances, security protocols could fail, causing a breach of privacy of medical information. In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By signing this form, I understand the following:

- I understand the laws that protect privacy and 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.
- I understand that I will 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 the right to future care of treatment.
- I understand that I have the right to expect all information obtained and recorded in the course of the telemedicine interaction and may receive copies of this information
- I understand that a variety of alternative methods of medical care my be available to me to choose from at any time and that my provider has explained the alternatives to my satisfaction.
- I understand that it is my duty to inform my provider of electronic interactions regarding my care, that I may have with other healthcare providers.
- I understand 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 and have discussed with my provider all of my questions, which have been answered to my satisfaction. I hear by 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 Authorized person for patient:_____Date:_____
If authorized signer, relationship to patient:_____
I have been offered a copy of this consent form (patient initials):_____