



## CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

- 1. PURPOSE.** The purpose of this form is to obtain your consent for a telemedicine consultation with a physician. The purpose of this consultation is to assist in the diagnosis and medication treatment.
- 2. RISKS.** A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy.
- 3. MEDICAL INFORMATION AND RECORDS.** All laws concerning patient access to medical records and copies of medical records apply to telemedicine.
- 4. NATURE OF TELEMEDICINE CONSULTATION.** Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken.
- 5. CONFIDENTIALITY.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections apply to information disclosed during this telemedicine consultation.
- 6. RIGHTS.** You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consult without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

**I have read and agreed to a telemedicine consultation.**