Informed Consent for Telemedicine Services

Patient Name:	Date of Birth:
Patient Location:	Student ID #:

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 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 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 a telemedicine interaction and may receive copies of this information.

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 it is my duty to inform health services of electronic interactions regarding my care that I may have with other healthcare providers.

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.

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 enough (e.g. poor resolution of images) to allow for appropriate medical decision making by the Health Services provider
- 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
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Patient Consent to The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine I hereby authorize Health Services to use telemedicine during my diagnosis and treatment. This telemedicine consent form is valid for one academic year.

Signature of Patient: _____ *Date:* _____

Revised 08/25/2020