



## **Informed Consent for Telemedicine Services**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### **About Telemedicine:**

Telemedicine involves the use of electronic communication technologies by a health care provider to deliver health care services to a patient when the patient and provider are at different locations.

### **I understand the following:**

- Telemedicine visits are generally not recorded, and video, audio, or images are not electronically stored. My provider will obtain my authorization to record if he/she recommends recording the visit for my record.
- Laws that protect privacy and confidentiality of medical information also apply to telemedicine.
- The doctor may bill my health care insurance for telemedicine services, and I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.
- 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 jeopardizing access to other available services or affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by advising my health care provider. As long as I do not revoke my consent, my health care provider may provide healthcare services to me via telemedicine without the need to sign a consent for each telemedicine encounter.
- Electronic systems used will incorporate security protocols, in accordance with Federal law, to protect the confidentiality of patient identification and will include measures to safeguard against electronic interception of the communication, however no guarantees have been provided.

**Benefits:** Potential benefits of telemedicine include improved access to health care.

**Risks:** I understand that there are potential risks associated with the use of technology for telemedicine services, including but limited to:

- The video connection may not work, or may stop working during the telemedicine visit;
- The video or sound may not be clear enough to be useful to effectively complete the telemedicine visit;



- I may need to reschedule an in-person visit if the health care provider believes the information able to be obtained during the telemedicine visit is not sufficient;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- Security protocols could fail, causing a breach of privacy of personal medical information.

<u><b>Certification of Patient:</b></u>	<u><b>Certification of Health Care Provider:</b></u>
<p>By signing below, I certify that I have been instructed on accessing telemedicine services and have had an opportunity to ask the health care provider all my questions concerning anticipated benefits, and potential risks, and all of my questions have been answered to my satisfaction. I hereby consent to having my health care provider provide health care services to me via telemedicine and accept any associated risks.</p> <hr/> <p>Patient Signature or Authorizer Individual Date/Time</p> <hr/> <p>Printed Name of Authorized Individual</p> <p><u>Role of Authorized Individual:</u>  <input type="checkbox"/> Parent   <input type="checkbox"/> POA/Legal Guardian   <input type="checkbox"/> Other: _____</p>	<p>I hereby certify that I have discussed with the individual granting consent, anticipated benefits, potential risks, and additional information describe in this consent.</p> <p><b><i>NOTE: If verbal consent is obtained in lieu of the patient's written informed consent, complete <b>VERBAL CONSENT CERTIFICATION</b> section.</i></b></p> <hr/> <p>Signature of Licensed Health Care Provider</p> <hr/> <p>Date/Time</p>

**VERBAL CONSENT CERTIFICATION**

The patient or authorized individual noted above confirmed that the Informed Consent for Telemedicine Services form was received via email, was accessed via the patient portal or practice website, or the form was read to them. The patient or authorized individual gave their verbal informed consent to proceed with receiving telemedicine health care services.

I hereby certify that I have discussed with the individual granting consent, anticipated benefits, potential risks, and additional information described in this consent.

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Signature of Licensed Health Care Provider
Date
Time



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Primary care for  
patients of all ages

