

## Informed Consent for Telemedicine Services

PATIENT NAME: _____	DATE OF BIRTH: _____	MEDICAL RECORD #: _____
LOCATION OF PATIENT: _____		
PHYSICIAN NAME: _____	LOCATION: _____	DATE CONSENT DISCUSSED: _____
CONSULTANT NAME: _____	LOCATION: _____	
CONSULTANT NAME: _____	LOCATION: _____	

### 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 by enabling a patient to remain in his/her ophthalmologist's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

### 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;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Please initial after reading this page: \_\_\_\_\_

**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 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 in 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 in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
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. My ophthalmologist has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my ophthalmologist of electronic interactions regarding my care that I may have with other healthcare providers.
7. 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.

**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 \_\_\_\_\_ (*name of ophthalmologist*) to use telemedicine in the course of my diagnosis and treatment.

*Signature of Patient (or person authorized to sign for patient):* \_\_\_\_\_ *Date:* \_\_\_\_\_

*If authorized signer,  
relationship to patient:* \_\_\_\_\_

*Witness:* \_\_\_\_\_ *Date:* \_\_\_\_\_

I have been offered a copy of this consent form (patient's initials) \_\_\_\_\_

Patient Name: \_\_\_\_\_ Medical Record No: \_\_\_\_\_

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

\_\_\_\_\_

Patient's/parent/guardian signature

\_\_\_\_\_

Date

\_\_\_\_\_

Time

\_\_\_\_\_

Witness signature

\_\_\_\_\_

Date

\_\_\_\_\_

Time

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*If authorized signer,  
relationship to patient:* \_\_\_\_\_

*Witness:* \_\_\_\_\_ *Date:* \_\_\_\_\_

I have been offered a copy of this consent form (patient's initials) \_\_\_\_\_

## TELEMEDICINE

### (Excluding E-mail)

**Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine..**

Patient's  
Initials

I understand the concept of telemedicine, as well as the particular electronic medium to be used.

I understand that at least two health care providers may be involved, the referring and the consulting providers.

I understand that although there has been great progress made in technology, this telemedicine encounter may still be in the experimental stage.

I understand that there may be limitations to image quality or other electronic problems that are beyond the control of the health care providers.

The nature and potential risks of this telemedicine encounter have been explained to me.

I understand that in lieu of this telemedicine encounter, I may seek health care elsewhere where I might have face-to-face contact with the health care provider.

I am aware that my referring provider has verified the credentials of the consulting provider and found all to be in order.

I understand that the telemedicine encounter may be a one time occurrence and that treatment and follow-up will remain the responsibility of my referring provider.

I understand that specific procedures may require additional informed-consent process.

I am aware that there are no guarantees with telemedicine.

The doctor has answered all of my questions.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have

3/03  
Revised 9/05, 12/05, 1/06, 6/07

answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

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Physician Signature/Date/Time

copy given to patient  
initial

original placed in chart  
initial

SA  
MP  
LE

3/03  
Revised 9/05, 12/05, 1/06, 6/07

*This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).*