CULLMAN REGIONAL

Patient Label

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____ DOB: _____ Medical Record Number: _____

Physician Name: _____ Location: _____

Consultant Name: _____ Location: _____ Date of Consultation: _____

1. I hereby understand that my health care provider wishes me to engage in a telemedicine consultation.

2. I understand that telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient information for the purpose of improving patient care. I understand the expected benefits of utilizing a telemedicine consultation includes improving access to medical care by enabling me to remain in my physician's office while my physician obtains consultation from a healthcare practitioner or specialist at a distant site. Furthermore, utilizing a telemedicine consultation may allow for more efficient medical evaluation and management.

3. Providers may include primary care physicians, specialists, and/or subspecialists. I understand that this consultation may involve electronic communication of my personal medical information, medical records, and medical images to other medical practitioners who may be located in other areas, including out of state.

4. 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 the direct patient/health care provider visit due to the fact that I will not be in the same room as my consulting health care provider. I understand that live two-way audio and video, and output data from medical devices/sounds/video files may all be used for diagnosis, therapy, follow-up or education.

5. I understand that 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. I understand that delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. In rare cases, I understand that a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

6. I have had the risks, benefits, and alternatives to a telemedicine consultation explained to me, and I am choosing to participate in the 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.

PATIENT CONSENT

I have read and understand the information provided 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 in a language that I understand. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____ (name of physician) to use telemedicine in the course of my diagnosis and treatment.

Legal Signature of Patient (or legal signature of person authorized to sign for patient): _____ *Date*: _____ *Time*: _____

If authorized signer, relationship to patient: _____

Explanation of why patient cannot sign: _____

Witness: _____ *Date*: _____ *Time*: ____

Created: 03/07/2018