# TELEMEDICINE PROGRAM
## TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient or parent/guardian) _____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. [**Note:** The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility.

I understand that some or all of my medical information may be used for teaching or educational purposes.

I agree to have my telemedicine medical records reviewed for the purposes of evaluation (data collection, analysis and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers. **DECLINE _____ (initials of patient)**

If clinical information regarding HIV status is included in my medical record for purposes of the telemedicine evaluation, I agree to the collection of these data for research purposes**. DECLINE _____ (initials of patient)**

**FOR DEMONSTRATIONS ONLY**: I agree to permit other persons who are not involved in my medical care to observe my evaluation. I understand that I may withdraw this permission at any time during my evaluation.
**DECLINE _____ (initials of patient)**

Signature of patient (or parent/guardian): _____ Date: _____

Please print the above name: _____

Signature of witness: _____ Date: _____

➲ *For withdrawal from a telemedicine evaluation, please complete the information on the back of this page*

**For Office Use Only**

Patient Name: _____ Local MRN: _____ Facility: _____

☐ **(MARK THIS BOX AND SIGN BELOW FOR WITHDRAWAL ONLY).** I have chosen not to participate further in this telemedicine evaluation.

Signature of patient (or parent/guardian): _____ Date: _____

Signature of witness: _____