South Coast PSYCHIATRY

Psychotherapy & Medication Management

TELEMEDICINE CONSENT FORM

I hereby authorize _____ [name of physician] to use telemedicine (telephone, email, text, and fax) in the course of my diagnosis and treatment. I understand that telemedicine involves the communication of my medical information orally via phone, internet or other telemedical devices to myself, as well as, to other physicians and other health care practitioners located in other parts of the state or outside of the state.

I understand I have all the following rights with respect to telemedicine:

Patient Choice of Care. I have the right to withhold or withdraw my consent to telemedicine at any time without affecting my right to future care or treatment and without risking the loss of my health coverage.

Access to Information. I have the right to inspect all medical information transmitted during a telemedicine consultation; and may receive copies of this information for a reasonable fee.

Confidentiality. I understand that the laws which protect the confidentiality of medical information apply to telemedicine; and that no information or images from the telemedicine interaction which identify me will be disclosed to researchers or other entities without my consent.

Potential Risks. I understand that there are risks from telemedicine, including the possibility, despite reasonable and appropriate efforts, that: the transmission of medical information could be disrupted or distorted by technical failures in transmission; the transmission of medical information could be interrupted by unauthorized persons. In addition, I understand that telemedical examinations or care may not be as complete as face-to-face examinations or care and that telemedicine does not negate or minimize the risks that may be inherent in a medical illness or condition. Additional potential risks may include:

_____

_____

Finally, I understand that it is impossible to list every possible risk, that my condition may not be cured or improved, and in rare cases, may get worse.

Consequences. I understand that by consenting to telemedicine my physician will communicate medical information concerning me to physicians and other health care practitioners located in other parts of the state or outside the state. Initial _____

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Benefits. I understand that I can expect benefits from telemedicine, but that no results can be guaranteed or assured. [Where applicable: Telemedicine provides me with access to medical care that otherwise would not have been available.]

I have read and understand the information provided above, I have discussed it with my physician or my physician's designee, and all my questions have been answered to my satisfaction.

Date: _____

_____ _____

Signature of patient / parent / guardian Print Name

Name and Address of Patient:

_____

_____

AGAINST PHYSICIAN'S ADVICE. [Where applicable] I understand that my physician advises that I not receive my care through telemedicine. Notwithstanding the recommendation of my attending physician, I choose to have my care delivered through telemedicine and hereby release my physician from any responsibility whatsoever for unfavorable or untoward results which I understand may occur as a result of my decision to receive my care through telemedicine.

Date: _____

_____ _____

Signature of patient / parent / guardian Print Name

Name and Address of Patient:

_____

_____