Insert Practice's

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Informed Consent for Telemedicine Services

Table to be completed by Provider:

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

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to [name of provider] providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

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. I may revoke my consent orally or in writing at any time by contacting [name of provider] at [contact information]. As long as this consent is in force (has not been revoked) [name of provider] may provider health care services to me via telemedicine without the need for me to sign another consent form.

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) _____