Informed Consent for Telehealth Consultations

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, specialists, 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
- Liver 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 the patient identification and imaging data and will include measures to safeguard the data 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 home while the physician obtains test results and consults from distant/other sites
- More efficient medical evaluation and management
- Obtaining expertise of distant

Possible Risks: As with any medical procedure, there are potential risks associated with the use of telemedicine. The risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (eg poor resolution of images) to allow for appropriate medical decision making by the physician and consultant
- 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 in 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 judgement errors

By Signing this form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed without my consent.
2. I understand that the physicians at the Allergy Associates do not act as my (or my child's) primary care and I should discuss all recommendations made by Allergy Associates with the primary care.
3. I understand I have the right to inspect all information obtained and recorded in the course of 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 to try these at any time. My physician explained the alternatives to me to my satisfaction.
5. I understand that telemedicine and electronic communication of my (or my childs) 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 (or my childs) primary care physician of electronic interactions regarding my childs care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits form the use of telemedicine in my (or my child's) 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 Allergy Associates to use telemedicine in the course of my diagnosis and treatment.

_____ _____

Patient Printed Name *Date*

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Patient Signature