Gateway Rehabilitation Center - Consent for Telemedicine

Patient Name **Client ID**

I understand that my healthcare provider at Gateway Rehabilitation Center is requesting that I participate in a telemedicine encounter.

My healthcare provider has explained to me how the video conferencing technology will be used to affect such an encounter. I understand that this encounter will not be the same as a direct patient/healthcare provider visit due to the fact that I will not be in the same room as my healthcare provider. The benefit of this encounter is I will have access to a healthcare provider through this encounter.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider(s) 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 others may also be present during the encounter at any time. I have the right to withhold or withdraw consent without affecting my right to future care or treatment.

I understand that I may revoke this consent verbally or in writing at any time except to the extent that action has been taken in reliance on it.

I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

I have read this document carefully, and understand the risks and benefits of the teleconferencing encounter and have had my questions regarding the procedure explained to my satisfaction.

Copy Accepted?*

- ○ Yes
- ○ No

Revoke Consent

- ○ Written request received to revoke consent.
- ○ Verbal request received to revoke consent.

Date of Revocation:

Revocation Comments

*** Indicates required field**

Patient Signature_____ Date_____

Staff Signature_____ Date_____