UCFS Healthcare

Consent Form/Telemedicine

Name: _____ **Date of Birth :** _____

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 practitioners, specialists, psychiatrists or clinicians. 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
- Live 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 patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to health care by enabling a patient and provider to remain in his/her home (or at a UCFS site or remote location) while the physician provides the assessment, intervention, treatment and if necessary obtain test results and/or consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

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

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- 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 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 judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, and the clinician or specialist. I will give my verbal permission prior to the entry of the additional personnel.
3. The provider will keep a record of the consultation in my medical record.

Please initial after reading this page: _____

Informed Consent for Telemedicine Page 2

4. RELEASE OF INFORMATION: ( ) and/or providers who provide professional services to the patient are authorized to furnish medical information from my medical record to the referring physician, if any, and to any insurance Company or third party payer for the purpose of obtaining payment of the account. ( ) is authorized to release information from my medical record to any other health care facility or provider to which my care may be transferred.
5. 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.
6. I understand that if I do not choose to participate in a telehealth 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.
7. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
8. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider or designee has explained the alternatives to my satisfaction.
9. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
10. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
11. I understand that I may expect the anticipated benefits from the use of telemedicine in my 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 provider 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 United Community & Family Services (UCFS) to use telemedicine in the course of my diagnosis and treatment.

_____ _____

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) _____