INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name:	Date of Birth:	Medical Record #:
Physician Name: Dr. Kadakia Location: San clemente Medi Center		Date Consent Discussed:

Introduction

Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through the use of interactive video, audio or other telecommunications technology. Additionally, a physical examination of you may take place, and video, audio, and/or photo recordings may be taken.

Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Anticipated Benefits:

- Improved access to medical care by enabling a patient to remain in his/her location while the physician may provide care from a distant site.
- 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;
- Delays in medical evaluation/treatment could occur due to deficiencies or failures of the electronic equipment;
- In rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to all of your 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 I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
2. I understand that the laws that protect the privacy and security of health information 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 authorization.
3. 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.
4. 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.
5. 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 physician has explained the alternative to my satisfaction.
6. 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.
7. I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have with other healthcare providers.
8. I understand that if my medical insurance coverage (except for government health programs) is not sufficient to satisfy the medical service charges in full, I will be fully responsible for payment.

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 Dr. Kadakaia (*name of physician*) 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