

Patient: _____

DOB: _____



Date: _____

Telemedicine Consent

I authorize Grayhawk Family Practice to utilize telemedicine technologies in determining my diagnosis and/or treatment. I understand telemedicine means the practice of healthcare delivery, diagnosis, consultation, treatment and transfer of medical data through interactive audio, video or data communications that occurs in lieu of the physical presence of the patient or physician.

Grayhawk Family Practice and its Providers
21803 N Scottsdale Rd. Ste 200
Scottsdale Az 85255
480-473-7003

Will be consulted through audio, video or data imaging and communications.

Benefits

The reason telemedicine is being utilized is for the following reason(s):

- Convenience of encounter for the patient.
- Access to healthcare technology not physically readily available.
- Need for expertise from a consultant not readily available.

Risks

The reasonably foreseeable risks of utilizing telemedicine technologies may include:

- Audio or visual images may not be as good as in person.
- Telemedicine physician cannot utilize the senses of touch and smell to assist in diagnosis, treatment or therapy.
- Telemedicine physician cannot obtain their own set of vital signs.

Alternatives

The possible alternatives may be:

- Travel distance to physically see my physician/consultant or undergo testing/procedure.
- Undergo therapy available locally which may not produce desired result.
- Go to local urgent care or emergency room.

Confidentiality

I understand every reasonable effort will be made to protect the security and confidentiality of my medical information which is copied and forwarded to the above named office, either through the mail or transmitted through electronic means as part of telemedicine.

Option Not to Participate

I understand I have the option of not participating in telemedicine and can withdraw from participation in utilizing telemedicine technology in my diagnosis or treatment at any time by expressing this to my physician or physician's office manager.

Do not sign unless you have read and thoroughly understand this form.

By signing this form, I am stating that I have read, understand, consent and agree to the above.

Patient/Legal Representative Signature

Date

Witness's Signature

Date