Informed Consent for Telemedicine Services

PATIENT NAME: _____ DATE OF BIRTH: _____

Telemedicine involves the use of electronic communications to enable health care providers, primary care practitioners and/or specialists, at different locations to share individual patient medical information for the purpose of improving patient care. It allows long-distance patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions. The information may include any of the following: Patient medical records, Medical images, Live two-way audio and/or video, and/or Output data from medical devices and sound and video files.

Expected Benefits: Improved access to medical care by enabling a patient to remain home in times of mobile limitation yet still have access to efficient medical evaluation and management; Enabling patient to remain in his/her provider's office (or at a remote site) while the physician obtains test results and consults from distant healthcare practitioners. Web-based application electronic systems used may incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data.

Possible Risks: There are potential risks associated with the use of telemedicine, including but not 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 rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors
- In rare instances, security protocols could fail, causing a breach of privacy of personal medical information

We at Enliven Medical Clinic will take all measures possible to safeguard your data, but we are unable to ensure the privacy policies and security of some web-based applications.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical 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 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.
3. 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.
4. 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 has explained the alternatives to my satisfaction.
5. 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.
6. I understand that email is not a secure way to transmit my protected health information and Enliven Medical Clinic will only use this method to send my protected health information upon my specific request.
7. I understand that I may expect the anticipated benefits from the use of telemedicine, but 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 Dr. Mozhgan Ashtari to use telemedicine in the course of my diagnosis and treatment. By engaging with Dr. Mozhgan Ashtari through electronic systems and applications, I agree that my conversation with my provider will contain my health information. Dr. Ashtari is not responsible for the privacy polices or security of the application service provider, and I am responsible to review the application's policies directly if I have questions.

I have been offered a copy of this consent form.

Signature of Patient _____ *Date:* _____