Absolute Dermatology & Skin Cancer Center
5207 Hickory Park Drive, Suite A Glen Allen, VA 23059
T: (804) 326-4448, F: (309) 326-4947 www.AbsoluteDermVA.com

Telemedicine Consent:

Details of Telemedicine:
Telehealth involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. I understand and agree that:

- I will not be in the same location or room as my medical provider.
- My provider is licensed in the state in which I am receiving services. I will report my location accurately during registration.

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:
Potential benefits of telehealth (which are not guaranteed or assured) include:

- Access to medical care if I am unable to travel to my provider's office.
- More efficient medical evaluation and management.
- During the COVID-19 pandemic, reduced exposure to patients, medical staff and other individuals at a physical location.

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).
- Limited or no availability of diagnostic testing and laboratories.
- Delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

Results and Patient responsibilities:

- I understand that my Provider's advice, recommendations, and or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my provider relies on information provided by me before and during our telehealth encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability.
- I understand that the level of care provided is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, it will be recommended that I present to the office.
- I have the right to receive face-to-face medical services at any time by traveling to a Patient First medical center that is convenient to me.

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.

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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.

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.

Printed Patient Name

Patient signature/ Date Witness signature/ Date

The undersigned hereby provides consent as the guardian of the above referenced minor patient

Patient/ legally responsible person signature/ Date Relationship to Patient