McDowell Mountain Gynecology

INFORMED CONSENT FOR TELEMEDICINE SERVICES

PATIENT NAME: _____ **DOB:** _____

CONSENT FOR MCDOWELL MOUNTAIN PROVIDERS TO PROVIDE TELEMEDICINE SERVICES WHEN AVAILABLE

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. The information bay be sued 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 or visual * Output data from medical devises

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging date and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS: * Improved access to medical care by enabling a patient to remain in his or her home while accessing physicians care. * 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 are 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. * 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 reactions or other judgment errors.

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING: I understand that the laws that protect privacy and confidentiality of medical information apply to telemedicine 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 with out my consent.

1. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in thru course of my care at any time with out affecting my right to future care or treatment
2. 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 the information for a reasonable fee.
3. 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 practitioner has explained the alternatives to my satisfaction.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners to assist in my care.
5. I understand that it is my duty to inform my practitioner of electronic interactions regarding y care that I may have with other health care professionals.
6. 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 to me regarding telemedicine. All my questions have been answered to my satisfaction I hereby give my consent for the use of telemedicine in my care:

Signature: _____ **Print:** _____ **Date**_____

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