COMPREHENSIVE
PRIMARY CARE

TELEMEDICINE CONSENT FORM

PATIENT NAME: _____ TODAY'S DATE: _____

PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine consultation. : A telehealth visit is between a patient and their provider through a secure online platform in connection with the following procedures and services:

Nature of the Telemedicine Consult:

- Your provider will discuss details of your medical history, examinations, x-rays, and tests through interactive video, audio, and telecommunication technology.
- A physical examination may take place.
- Your provider may take video, audio, or photo recordings of you during the procedure or service

Medical Information and Records: All existing laws regarding your access to medical information and copies of your medical records still apply to telemedicine consultations. Please note, not all telecommunications are recorded and stored. Additionally, disseminating any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.

Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with telemedicine consultations. All existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telemedicine consultation.

Rights: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

Risks, Consequences, and Benefits: You are advised of all the potential risks, consequences, and benefits of telemedicine. Your health care provider discussed the information provided above with you. You had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions are answered, and you understand the written information provided above.

I, _____, agree to participate in a telemedicine consultation/virtual visit for the procedures prescribed above should I need such a visit.

PATIENT NAME (Please Print): _____ PATIENT DOB: _____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____DATE: _____