

MRN

Name

DOB

## **Informed Consent for Telemedicine Services**

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Consulting Provider Name: \_\_\_\_\_ Location: \_\_\_\_\_

Credentials: \_\_\_\_\_

Telemedicine involves the use of audio, video or other electronic communications for a distant health care provider to interact with you, to consult with your healthcare provider, and/or review your medical/mental health information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through the use of interactive video, audio, transmission of medical information and images, or other telecommunications technology. Additionally, a physical examination of you may take place.

Electronic systems used will include network and software security methods to protect the privacy and security of health information and imaging data, and will include measures to protect the data to ensure its completeness against intentional or unintentional wrongdoing.

### **Anticipated Benefits:**

- Improved access to medical care by enabling a patient to remain in his/her location while the provider may provide care from a distant site.
- Increased ability to receive medical advice/ treatment from a health provider in a more time-efficient, convenient manner.

### **Possible Risks:**

As with any medical procedure, there are potential risks associated with the use of telemedicine technology. The University of Vermont Health Network-Porter Medical Center (UVMHN-PMC) believes the likelihood of these risks happening is very low. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) or your specific medical condition might not allow for appropriate medical decision making by the physician. An in-person visit/consult with the provider might still be necessary afterward.
- Delays in medical evaluation and treatment or loss of information could occur due to deficiencies or failures of the equipment or technology.
- In rare instances, despite reasonable efforts on our part, security protocols could fail, resulting in a breach of privacy of personal health information.
- In rare cases, a lack of access to all of your medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

### **By Signing this Form, I Understand the Following:**

1. I understand that all services the provider delivers to me through telemedicine will be delivered over a secure connection that encrypts data and uses password protected screen savers and data files that comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, public law 104-191.
2. This Service conforms with patient privacy and confidentiality laws with respect to protected health information as outlined by the HIPAA. The Service will obtain my consent prior to sharing any patient-identifiable information to a third party for purposes other than treatment, payment or health care operations or as otherwise permitted under HIPAA.

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3. All existing confidentiality protections under federal and state law apply to information used or disclosed during my telemedicine consultations/visit.
4. I understand that the provider determines whether or not the conditions being diagnosed and/or treated is appropriate for a telemedicine encounter.
5. I understand that I will be informed of the presence of any individual who will be participating in or observing my consultation with the provider at the distant site and that I will be asked for my permission for that participation or observation.
6. 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. Either my health care provider(s) or myself may discontinue the telemedicine consult/visit if it is felt that the audio or video connections are not adequate for the situation.
7. I understand that I have the right to inspect all information obtained during the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
8. I understand that it is my duty to inform other health care providers involved with my care of this telemedicine consult.
9. I understand that I may receive a bill from the provider of this telemedicine consult as well as a bill for a facility fee from this site of service.
10. I understand that neither the treating provider nor I will create an audio/video recording of any of our telemedicine encounters.
11. I understand that while I may benefit from telemedicine, results cannot be guaranteed or assured.
12. I permit transmissions for prescription refills, appointment scheduling, patient education to be executed using telemedicine technology.

**If I am to receive a Store and Forward (S&F) Telemedicine consult:**

- I have the right to receive an in-person consultation with the health care provider within a reasonable period of time following my notification of results of the S&F consult. Receiving the S&F service will not prevent me from receiving real time telemedicine or in-person services at a future date.

**Patient Consent to the Use of Telemedicine:**

I have read and understand the information provided above regarding telemedicine, have had the opportunity to ask questions about this information, 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 and authorize the transmission of any relevant medical information to providers and their staff involved in my medical or mental health care.

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature of Patient (or person authorized to sign for patient)

If authorized signer, Relationship to patient: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_