Corina B. Going, ND
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Informed Consent for Telemedicine Services

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. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used 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 video

• Output data from medical devices and sound and video files

Security

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. In my practice I use a HIPAA compliant Zoom platform and sessions are not recorded.

Expected Benefits

• Improved access to medical care by enabling a patient to remain at a remote site

• More efficient medical evaluation and management

• Obtaining expertise of a distant specialist

• Maintaining patient safety during a pandemic or declared state/federal emergency

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:

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- In rare cases, information transmitted may not be sufficient (ie. 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 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 interactions, allergic reactions, or other judgment

In the event that my telemedicine session is disrupted or distorted by technical failures, I would like to be contacted via telephone at: ____________________________________

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 according to the patient medical records policies set by the clinic. Telemedicine sessions are not recorded.
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.
5. I understand that my telemedicine appointment may involve electronic communication of my personal medical information to other medical practitioners if a referral is warranted.

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6. I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have had with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine, but that no results can be guaranteed or assured.

8. I understand that telemedicine has its limitations, and that there is no guarantee that this telemedicine consultation will eliminate the need for me to see a health care provider in person. I agree to consult with a local health care provider in person for any necessary physical examinations.

By signing this form, I certify:

• That I have read or had this form read and/or had this form explained to me.

• That I fully understand its contents, including the risks and benefits of telemedicine.

• That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

• I hereby authorize (clinic name) and its medical staff to use telemedicine in the course of my diagnosis and treatment.

☐ Checking this box serves as my signature and indicates agreeement with the above policies.

Patient Name: ____

Date: _____________