ARTHRITIS CONSULTANTS OF TIDEWATER

PATIENT CONSENT TO THE USE OF TELEMEDICINE SERVICES

I have read and understand the information provided below regarding telemedicine, I 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. I hereby authorize for the providers at Arthritis Consultants of Tidewater (Drs Siegel, Sherwood, Cannon, Keck or NPs Sally Clark/Fredilynn Lansangan) to use telemedicine in the course of my diagnosis and treatment.

Patient Name (print): _____

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

If authorized signer, relationship to patient: _____

Date: _____

Telemedicine involves the use of electronic communications to let health care providers communicate through a live two-way audio and video virtual visit with their patients at a different location e.g., home.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home while having a virtual health visit with their physician/provider to obtain e.g., test results, medical consult etc.
- More efficient medical evaluation and management.

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).
- 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

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 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. My provider/provider's office has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.