Telemedicine Patient Consent/Refusal Form

Patient name: _____Date of Birth _____

Please **read the entire form carefully** and then before signing it, ask your physician any additional questions you may have.

1. **Purpose:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following provider: _____

2. **Nature of Telemedicine Consult:** During the telemedicine consultation:

    a. Details of your medical history, examinations, and test results will be discussed with you through the use of interactive video, audio and telecommunication technology
    b. A physical examination of you may take place
    c. A non-medical technician may be present in the telemedicine studio to aid in the video and documentation of the visit
    d. Video, audio and/or photo recordings may be taken of you during the procedure or service

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

4. **Confidentiality:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine visit, and all existing confidentiality protections under federal and Illinois state law apply to information disclosed during this telemedicine visit.

5. **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 benefits to which you would be otherwise entitled.

6. **Risk, consequence's, and benefits:** You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care provider has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine visit. All your questions have been answered and you understand the written information provided above.

7. **Possible risks:**
    a. In some cases, information transmitted might not be sufficient for diagnosis
    b. There could be a delay in medical evaluation and treatment that could occur due to deficiencies or failure in equipment or technology
    c. In rare cases, security protocols could fail, causing a breach of privacy of personal medical information

I agree to participate in a telemedicine visit for the practice/provider listed above.

Signature: _____ Date: _____

If signed by someone other than the patient, indicate the relationship: _____

If refuse to participate in a telemedicine visit for the practice/provider listed above:

Signature: _____ Date:_____

If signed by someone other than the patient, indicate relationship: _____