

INFORMED CONSENT FOR TELEMEDICINE SERVICES

PATIENT NAME: _____

DATE OF BIRTH: _____

LOCATION OF PATIENT: _____

Introduction

Telemedicine involves the use of electronic communications (telephone, computer, etc.) to enable health care providers (doctors, nurses, physician assistants, and others) at a different location from the patient to share medical information with that patient for the purpose of improving access to patient care. 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

The electronic systems used will attempt to incorporate 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 corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides medical information from a distant site
- Limiting the spread of COVID-19 and other communicable diseases
- Ability to obtain consultation from a distant medical specialist without traveling
- Conservation of personal protective equipment (PPE) such as gloves and masks to reduce shortages for healthcare providers
- Allow medical evaluation and management of patients who are unable to travel

Possible Risks:

As with any medical procedure, there are risks associated with the use of telemedicine. These risks include, but may not be limited to:

- Information transmitted may not be sufficient to allow for appropriate medical decision making by the health care provider. For instance, certain parameters of the eye examination cannot be tested remotely, such as eye pressure. In addition, there may be poor resolution of images. This may cause a delay in medical evaluation and treatment.

- Security protocols could fail, causing a breach of privacy of personal medical information.
- A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical errors.

PATIENT’S ACCEPTANCE OF RISKS

By signing this form, 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 will be disclosed to researchers or other entities without my consent.

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.

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.

Telemedicine may involve electronic communication of my personal medical information to other medical practitioners located elsewhere, including out of state.

I understand that no results from the use of telemedicine can be guaranteed or assured.

Consent. By signing below, you consent (agree) that:

- You have read this informed consent form, or someone has read it to you.
- You understand the information in this informed consent form and all of your questions have been answered.
- You have been offered a copy of this informed consent form.

I hereby authorize Dr. Ledoux, Dr. Doshi and Dr. Johnson of Specialized Pediatric Eye Care to use telemedicine in the course of my diagnosis and treatment.

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

If authorized signer, relationship to patient: _____

Witness Date