TELEMEDICINE PROGRAM
TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient or parent/guardian) _____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be reviewed by a doctor and other persons involved in my medical or mental health care. [**Note**: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate of am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility.

Signature of patient (or parent/guardian): _____

Please print the above name: _____

Signature of witness: _____

☐ **(MARK THIS BOX AND SIGN BELOW FOR WITHDRAWAL ONLY).** I have chosen not to participate further in this telemedicine evaluation.

Signature of patient (or parent/guardian): _____ Date: _____

Signature of witness: _____

For Office Use Only

Patient Name: _____ Local MRN: _____ Facility: _____