

# THE PSYCHIATRY GROUP PLLC

## TELE-MEDICINE INFORMED CONSENT FORM

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 recorder 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 this time. My provider 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.
6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that i may have with other healthcare providers.
7. I understand that i may expect the anticipated benefits from the use of telemedicine in my care. But that no results can be guaranteed or assured.
8. I understand, acknowledge and agree that the following must be strictly complied with if I receive direct access telemedicine services:
  - a. I shall be physically present in the state the provider is licensed;
  - b. I do not use controlled substances;
  - c. I will be referred to the clinic for services if the provider determines I am unstable to receive direct access telemedicine services;
  - d. I will not receive direct access telemedicine services if I am in crisis.

Initials:

## **Patient Consent To The Use of Telemedicine**

I have read and understand the information provided above regarding telemedicine, 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 \_\_\_\_\_(name of provider) to use telemedicine in the course of my diagnosis and treatment.

Please initial after reading this page: \_\_\_\_\_

Signature of patient ( or person authorized to sign for patient) \_\_\_\_\_

Date: \_\_\_\_\_

If authorized signer, relationship to patient: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

I have been offered a copy of this consent form( patient's initial) \_\_\_\_\_