



Student Health Center

Consent for Telemedicine Services

Introduction:

Telemedicine is the delivery of healthcare services when the healthcare provider and patient are not in the same physical location through the use of technology. Providers may include the college physician, nurse practitioners, or physician assistants. Electronically transmitted information may be used for diagnosis, therapy, follow-up and/or patient education, and may include any of the following.

- Phone consultation
- Interactive audio, video, and/or data communications.

The interactive electronicsystems used will incorporate network and software 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 intentional or unintentional corruption.

Potential Benefits:

1. Improved access to medical care by enabling a patient to remain in the location at which they are while the medical provider consults from a remote location.
2. Obtaining the expertise of a distant specialist.

Potential Risk:

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

1. Information transmitted may not be sufficient (e.g. poor resolution) to allow for appropriate medical decision making by the medical provider.
2. The consulting medical provider may not be able to provide medical treatment to the patient through the use of telemedicine equipment nor provide for or arrange for any emergency care that may be required.
3. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
4. Security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, I understand and agree to the following:

1. The laws that protect the privacy and confidentiality of medical information also apply to telemedicine. No information obtained during a telemedicine encounter which identifies me will be disclosed to researchers or other entities without my consent.
2. I have the right to withhold or withdraw my consent to the use of telemedicine during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment, nor will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled.
3. I have the right to inspect all information obtained during the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. A variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time.
5. Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other locations.
6. I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. My condition may not be cured or improved, and in some cases, may get worse.

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 my questions have been answered to my satisfaction. I hereby give my informed consent for the use of in my medical care.

Signature of Patient: _____

Date: _____