



Informed Consent for Telemedicine Services

Table to be completed by Provider:

Patient Name: _____	Date of Birth: _____	Medical Record #: _____
Location of Patient: _____		
Physician Name: _____	Location: _____	
Consultant Name: _____	Location: _____	Date Consent Discussed: _____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to [_____] providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments, coinsurances, or deductible that applies to my telemedicine visit. If my insurance does not cover telemedicine, I understand I will be responsible for the balance.

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. I may revoke my consent orally or in writing by contacting, Lisa Hobbs, Privacy Officer at (972) 317 – 6000. As long as this consent is in force (has not been revoked) [_____] may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person

Authorized to sign for patient): _____ ***Date:*** _____

If authorized signer, relationship to patient: _____ ***Date:*** _____

Witness: _____ ***Date:*** _____

I have been offered a copy of this consent form (patient's initials) _____