

Consent to Use Telemedicine

Patient's Name _____ Today's Date _____
Patient's Date of Birth _____ Provider's Name _____

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my medical provider to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My medical provider is located in and licensed by the State of California. My medical provider may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my medical provider. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.
2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my medical provider and my medical provider's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.
3. My medical provider believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.
4. If my medical provider believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my medical provider may discontinue telemedicine services and schedule an in-person consultation with my medical provider or refer me to a healthcare provider in my area who can provide such services.
5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in-person healthcare services with my medical provider.
6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my medical provider and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment, and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my medical provider to me will be encrypted during transmission and will be stored only by my medical provider or a service provider selected by my medical provider. I understand the dissemination of any personally identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to “auto-remember” usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my medical provider and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

11. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my medical provider and all of my questions were answered to my satisfaction.

Parent or Guardian’s Name (Print)

Date

Parent or Guardian’s Signature

Or

Patient’s Signature
(if 18 years old or over)