



TELEMEDICINE PATIENT CONSENT/ REFUSAL FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s)

2. **NATURE OF TELEMEDICINE CONSULT:** During the telemedicine consultation:
 - a. Details of your medical history, examinations, x-ray, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
 - b. A physical examination of you may take place.
 - c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
 - d. Video, audio and/or photos recording may be taken of you during the procedure(s) or services(s)
3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical record apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telemedicine interaction to researchers or other shall not occur without your consent.
4. **CONFIDENTIALITY:** Reasonable and appropriate effort have been made to eliminate any confidentiality risk associated with the telemedicine consultation and all existing confidentiality protections under federal and New York state all apply to information disclosed during this telemedicine consultation.
5. **RIGHTS:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your rights to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. **DISPUTES:** You agree that any dispute arising from the telemedicine consult will be resolved in New York State and the New York state laws shall apply to all disputes.
7. **RISK, CONSEQUENCES AND BENEFITS:** You have been advised of all the potential risk, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information above.

I agree to participate in a Telemedicine consultation for the procedure(s) described above.



Signature: _____

If signed by someone other than the patient, indicate relationship: _____

I refuse to participate in a telemedicine consultation for the procedure(s) described above.

Signature: _____

If signed by someone other than the patient, indicate relationship: _____

DATE: _____

TIME: _____

WITNESS: _____

DATE: _____

TIME: _____