Informed Consent for telemedicine Services

Telemedicine involves using electronic communication to enable health care providers the ability to care for a patient while at different locations for the purpose of family convenience, in an emergency, to offer guidance,etc. Providers may include physicians, physician assistants, or nurse practitioners. The information obtained during the telemedicine visit can be used for diagnosis, therapy, and follow-ups.

Electronic communication used by the practice is HIPPA compliant to protect the patient's medical information.It uses live 2-way audio and video communication, and may be limited to audio only, in some cases.

Risks to using telemedicine:

- Poor image/resolution may make it difficult to allow for appropriate medical decision making from the provider.
- In very rare cases, security processes could fail and cause a breach in privacy of personal medical information.
- In rare cases, a lack of access to the full patient's medical record could result in adverse drug reactions, allergic reactions, or other judgment errors.

By signing this form, I understand the following:

1. I understand that the laws that protect my medical information and privacy also apply to telemedicine services and that none of the information obtained during a telemedicine visit will be disclosed to other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent for telemedicine services at any time during my care without it affecting my future care or treatment.
3. I understand that I have the right to all information obtained during a telemedicine service and may receive copies of this information for a reasonable fee.
4. I understand that calling for medical advice, consultation, during or outside of normal business hours may result in a telemedicine visit and associated charge.

I have read and understand the information provided in this form regarding telemedicine services. I have had the opportunity to ask questions and received answers to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Patient(s) Name:_____DOB:_____Date:_____

_____DOB:_____Date:_____

_____DOB:_____Date:_____

Parent/Guardian Name:_____Relationship:_____

Witness:_____Date:_____

Chopra Pediatrics
1224 Seventh Ave
Altoona PA 16602
Office: 814-944-8784
Fax: 814-944-8625
Choprapeds.com

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