ALLIED PEDIATRICS
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Patient Name: _____ **Date of Birth:** _____

Parent Name: _____

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION AND SERVICES

Purpose and Benefits: The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a health care provider at a distance. The purpose of this electronic communication is to use telemedicine to enable patients to get medical care by heath care providers without the inconvenience of traveling.

Possible Risks: As with any medical visit, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s); Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment; In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. 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.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.

5. I understand that telemedicine involves electronic communication and potential risk may include interruptions and technical difficulties.

6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.

7. I understand that I will have a direct conversation with my Provider, during which I will have the opportunity to ask questions and a discussion/treatment plan will be in a language that I understand.

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

I hereby authorize Allied Pediatrics to use telemedicine in the course of my diagnosis and treatment.

Parent Name: _____

Parent Signature: _____ **Date:** _____