Bluegrass Community Health Center

TELEMEDICINE CONSENT FORM

Patient First Name	Last Name	Middle	Patient Date of Birth:

This means that I and/ or my healthcare provider other virtual connection, be able to consult with the above consultant about my condition.

My healthcare provider has explained to me how the video conferencing technology to be used to affect such a consultation will not be the same as a direct patient/healthcare provider visit due to the fact that I will not be in the same room as my healthcare provider or consultant. I understand there are potential risks with this technology:

1. The video connection may not work or that it may stop working during the consultation.
2. The video picture or information transmitted may not be clear enough to be useful for the consultation.
3. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the video conferencing connections are not adequate for the situation.
4. I may be required to go to the location of the consultant, if it is felt that the information obtained via telemedicine was not sufficient to make a diagnosis.

The benefits of a telemedicine consultation are:

1. You may not need to travel to the consult location.
2. You have access to a specialist through this consultation.
3. Other:____

I give consent that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consultant in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) Omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine room, and or (3) terminate the consultation at any time.

In an emergent consultation, I understand that the responsibility of the telemedicine consultant is to advise my local healthcare provider and that the consultant's responsibility will conclude upon termination of the video conference connection.

I understand that billing will occur from my healthcare provider.

I authorize the release of any relevant medical information about me to the consultant, any staff the consultant supervises, third party payers and other healthcare providers who may need this information for continuing care purposes.

I hereby release Bluegrass Community Health Center, its personnel and any other person participating in my care from any and all liability which may arise from the taking and authorized use of such videotapes, digital recording devices, and photographs.

I have read this document and understand the risk and benefits of the telemedicine consultation and have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction. I hereby consent to participate in a telemedicine visit under the conditions described in this document.

_______________________________________ _________________

Patient or Parent/Legal Guardian Signature **Date**

_______________________________________ _________________

Witness **Date**