# Telemedicine Consent

## TELEMEDICINE PATIENT CONSENT FORM

**Purpose:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedures and/or services:

**Nature of the Telemedicine Consult:**

- Details of your medical history, examinations, x-rays, and test will be discussed through the interactive video, audio, and telecommunication technology.
- A physical examination may take place
- Video, audio and/or photo recordings may be taken of you during the procedure or service

**Medical Information and Records:** All existing laws regarding your access to medical information and copies of your medical records still 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 entities shall not occur without your consent.

**Confidentiality:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and South Carolina state law apply to information disclosed during this telemedicine consultation.

**Rights:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

**Disputes:** You agree that any dispute arriving from the telemedicine consult will be resolved in South Carolina, and that SC law shall apply to all disputes.

**Risks, Consequences and Benefits:** You have been advised of all of the potential risks, consequences and benefits of telemedicine. Your health care provider 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 provided above.

**Patient Name (Please Print)**: ____________________________________________________________

✓ **I *agree* to participate in a telemedicine consultation for the procedures prescribed above**

Signature:_________________________________________________________________

Date: _______________

Relationship to patient if patient *isn't* signing: _____________________________________

✓ **I *refuse* telemedicine consultations**

Signature:_________________________________________________________________

Date: _______________

Relationship to patient if patient *isn't* signing: _____________________________________