

## INFORMED CONSENT FOR TELEMEDICINE SERVICES

<b>PATIENT NAME:</b> _____	<b>DATE OF BIRTH:</b> _____	MEDICAL RECORD #: _____
LOCATION OF PATIENT: _____	_____	_____
PHYSICIAN NAME: _____	LOCATION: _____	<b>DATE CONSENT DISCUSSED:</b>
CONSULTANT NAME: _____	LOCATION: _____	
CONSULTANT NAME: _____	LOCATION: _____	

### Introduction

Telemedicine is the delivery of healthcare services through the use of technology when the healthcare provider and patient are not in the same physical location. Providers may include primary care practitioners, specialists, and/or subspecialists. Electronically-transmitted information may be used for diagnosis, therapy, follow-up and/or patient education, and may include:

- Patient medical records
- Live, interactive audio, video, and/or data communications
- Medical images
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data; they will also include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Sleep Center Hawaii utilizes a secure telemedicine platform under a healthcare plan/subscription, which is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

*The potential benefits and risks may include, but are not limited to the following:*

### EXPECTED BENEFITS

- ✓ Improved access to medical care by allowing for the delivery of healthcare services when provider and patient are unable to be in the same physical location and/or by enabling a patient to remain in the provider's office (or at a remote site) while provider obtains test results and consults from other healthcare practitioners at distant/other sites.
- ✓ More efficient medical evaluation and management.
- ✓ Obtaining expertise of a distant specialist

### POSSIBLE RISKS

- In rare cases, insufficiency of information transmitted (e.g. poor resolution of images) hindering appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment due to deficiencies or failures of the equipment;
- In very rare instances, failure of security protocols causing a breach of privacy of personal medical information;
- In rare cases, lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgment errors

### Patient Consent to the Use of Telemedicine

By signing this form, I understand and agree to the following:

1. The laws that protect privacy and the confidentiality of medical information also apply to telemedicine; information obtained in the use of telemedicine which identifies me will not be disclosed to researchers or other entities without my consent.
2. 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 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. A variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time. My physician or such assistants has explained the alternatives to my satisfaction.
5. Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my physician or such assistants of electronic interactions regarding my care that I may have with other healthcare providers.
7. I may expect the anticipated benefits from the use of telemedicine in my care, but no results can be guaranteed or assured.

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 \_\_\_\_\_ (Provider name) to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient) \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient (if not self) \_\_\_\_\_

Witness \_\_\_\_\_ I have been offered a copy of this consent form. (Initial above)