Informed Consent for Telemedicine Services

Patient Name:		Date of Birth	Medical Record #
Patient Location:			
Phone #:	Email:		
Physician Name: Physician Location: Physician License No.:		Date Consent Discussed:	
Phone #:(323)954-1788	Fax #:(323)954-1822		

Introduction: Telemedicine involves use of electronic communications to enable health care providers and patients at different locations to share individual patient medical information for the purpose of patient care. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: (1) patient medical records; (2) live two-way audio and video; and (3) output data from medical devices and sound and video files.

Expected Benefits: The anticipated benefits include: (1) improved access to medical care by enabling a patient to remain at a more convenient remote site and receive medical care from a distant/other location(s) via the telemedicine network; (2)more efficient medical evaluation and management; and (3) obtaining expertise of a distant specialist.

Possible Risks: As with any medical procedure, 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;
- In rare cases, a lack of access to complete medical records may result in adverse results or other judgment errors

By signing this form, I understand the following:

1. I understand that I, or my legal representative, have the right to withhold or withdraw consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient's legal representative would otherwise be entitled.

2. I understand that the federal and state 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.

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, which shall not exceed the actual cost of providing these copies.

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. The alternatives have been explained to me to my satisfaction.

Please initial after reading this page: _____

5. I understand that 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 of electronic interactions regarding my care that I may have with other healthcare providers.

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

Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with a representative designated by Abraham Ishaaya M.D. APC or one of its affiliates, 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 the use of telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____ *Date:* _____

If authorized signer, relationship to patient: _____

Witness Signature: _____ *Date:* _____

I have been offered a copy of this consent form (patient's initials): _____