Telemedicine Informed Consent Form

I _____, being physically located in California, hereby consent to engaging in telemedicine with _____ as part of my medical treatment. I understand that "telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine involves the communication of my medical information both orally and visually, to Dr. Gosain, a health care practitioner located in California.

I understand that I have the following rights with respect to telemedicine:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. I understand that the audiovisual information that is transmitted electronically will be encrypted during transmit and will not be stored. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my consent. I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
3. I understand that there are benefits, risks and alternatives involved with telemedicine. Benefits include having access to medical care without having to travel outside of my local community. A potential risk of telemedicine is that because of my specific medical conditions, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Despite reasonable efforts on the part of my physician, the transmission of my medical information could be disrupted or distorted by technical failures. In rare circumstances, security protocols could fail causing a breach of patient privacy.
4. I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my physician believes I would be better served by another form of services (for example face-to-face services) I will be referred to a physician who can provide such services in my area.
5. I understand that I may benefit from telemedicine, but the results cannot be guaranteed or assured.
6. I understand that I have a right to access my medical information and copies of my medical records in accordance with California law.

I have read and understand the information provided above. I have discussed any questions that I might have with our designated staff, and all of my questions have been answered to my satisfaction.

Signature _____ Date:_____