

CECA Informed Consent for Telemedicine Services
3855 Gaskins Rd, Henrico, VA 23233, 804-217-6363

PATIENT NAME: _____ DOB: _____ MRN: _____

Introduction to TeleHealth Services

Telemedicine involves the use of electronic communications (telephone, computer, etc.) to enable health care providers (doctors, nurses, physician assistants, and others) at a different location from the patient to share medical information with that patient for the purpose of improving access to patient care.

The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

Medical records, images, medical device data, sound and video files, Live audio and video interaction

CECA will attempt to employ security protocols to safeguard and ensure data integrity, to protect patient confidentiality.

Expected Benefits:

- Improved access to medical care
- Limiting the spread of COVID-19 and other communicable diseases
- Ability to obtain consultation from a distant medical specialist without traveling
- Conservation of personal protective equipment (PPE)
- Allow medical evaluation and management of patients who are unable to travel

Possible Risks: As with any medical procedure, telemedicine has associated risks, including but not limited to:

- Information transmitted may not be sufficient to allow for appropriate medical decision making by the health care provider. For instance, certain parameters of the eye examination cannot be tested remotely, such as eye pressure. Image resolution may be poor. This may cause a delay in medical evaluation and treatment.
- Security protocols could fail, causing a breach of privacy of personal medical information.
- A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical errors.

PATIENT'S ACCEPTANCE OF RISKS: By signing this form, I understand that:

- The laws that protect privacy and the confidentiality of medical information also apply to telemedicine. Information obtained via telemedicine will not be disclosed to other entities without my consent.
- 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.
- 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.
- Telemedicine may involve electronic communication of my personal medical information to other medical practitioners located elsewhere, including out of state.
- I understand that no results from the use of telemedicine can be guaranteed or assured.

Consent: By signing below, you consent (agree) that:

- You have read this informed consent form, or someone has read it to you.
- You understand the information in this informed consent form and all of your questions have been answered.
- You have been offered a copy of this informed consent form.

I hereby authorize CECA Providers and/or their assistants to use telemedicine in the course of my care.

Patient/Representative Signature _____ Date _____
(Verbal Consent is acceptable with representative discussion and review, signature not required)

Witness Signature _____ Date _____