MERIDIAN
PSYCHIATRIC PARTNERS

INFORMED CONSENT: TELEMEDICINE SERVICES

PATIENT INFORMATION

PATIENT NAME | BIRTHDATE | DATE

☐ I understand that this Telemedicine Consent Form is extended to include all providers at Meridian Psychiatric Partners.

Telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different location than the healthcare provider. This may be for the purpose of diagnosis, treatment, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through the use of interactive video, audio or other telecommunications technology. Additionally, a physical examination of you may take place, and video, audio, and/or photo recordings may be taken.

All efforts will be made to utilize electronic systems with network and software security protocols to protect the privacy and security of health information and to safeguard the data against corruption. However, the mode of communication used during telehealth consultation has the potential to be less secure than in person consultation and may be subject to additional privacy risks.

ANTICIPATED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides care from a distant site
- Limiting the spread of airborne diseases
- More efficient medical evaluation and management
- Ability to obtain consultation of a distant specialist
- Conservation of personal protective equipment such as gloves and masks to reduce shortages for healthcare providers

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, it may be determined that the information transmitted is of poor quality, requiring a face to face visit or rescheduled telemedicine visit. This may cause a delay in medical evaluation/treatment.
- Security protocols could fail or not be available, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to all of your medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

1. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
2. I understand that all efforts will be taken to protect the privacy and security of health information, and that no information obtained in the use of telemedicine which identifies me will be intentionally disclosed to researchers or other entities without my authorization.
3. I understand that 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.

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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. My healthcare provider has explained the alternative to my satisfaction.
5. I understand that the telemedicine visit may occur with a licensed medical provider who is not licensed in my state of residence. I also understand there may be electronic communication of my personal medical information to other medical providers who may be located in other states.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The above-mentioned people will all maintain confidentiality of the information obtained.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine. I have discussed and had an opportunity to ask my healthcare provider questions. All of these questions have been answered to my satisfaction.

SIGNATURE

☐ I hereby **AUTHORIZE** Meridian Psychiatric Partners to use telemedicine in the course of my diagnosis and treatment.

☐ I hereby **REFUSE** Meridian Psychiatric Partners to use telemedicine in the course of my diagnosis and treatment.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT (IF GUARDIAN SIGNATURE) _____

WITNESS _____ DATE _____

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

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