346 Deep South Farm Road
Blairsville GA 30512
706-745-9417

809 East Main Street
Blue Ridge GA 30513
706-632-1155

229 Chatuge Way
Hiawassee GA
706-896-7858

Informed Consent for Telemedicine Services Risks & Benefits

Patient Name:	Date of Birth:	Medical Record #:
Date Consent Discussed:		

Introduction

Telemedicine involves the use of electronic communications to enable health care provider at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialist. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- 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 will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home (or at a remote site) while the health care provider renders medical services to the patient.

- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. The 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 drug interactions or allergic reactions or other judgement errors;

Patient Signature: _____ Date:_____

Guardian/POA Signature: _____ Date:_____

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Telemedicine Member Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

GA MED ID#: _____

1. **PURPOSE**: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or services(s). For more information, see Informed Consent for Telemedicine Services Risks & Benefits form.
2. **NATURE OF TELEMEDICINE CONSULT**: During the telemedicine consultation:
   a) Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b) A physical examination of you may take place.
   c) A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d) Video, audio, and/or photo recordings may be taken of you during the procedure(s) or service(s).
3. **MEDICAL INFORMATION & Records**: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. **CONFIDENTIALITY**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telemedicine consultation.
5. **RIGHTS**: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. **DISPUTES**: You agree that any dispute arriving from the telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

7. **RISKS, CONSEQUENCES & BENEFITS**: You have been advised of all the potential risks, consequences, and benefits of telemedicine. Your health care provider has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.
8. COVERAGE: Visit is still subject to copays and deductibles and patient will be responsible in the event of noncoverage by insurance.

I agree to participate in a telemedicine consultations for the procedure(s) described above.

Signature:_____ Date:_____

If signed by someone other than the patient, indicate relationship: _____

Witness Signature: _____ Date:_____