CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

PURPOSE.
The purpose of this form is to obtain your consent for a telemedicine consultation with a physician. The purpose of this consultation is to assist in the diagnosis or treatment of the patient.

NATURE OF TELEMEDICINE CONSULTATION.
Telemedicine involves the use of audio, video or other electronic communications to interact with you/ your child, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal information may be discussed with other health care professionals through the use of interactive video, audio and telecommunications technology. Additionally, a limited physical examination of the patient may take place, and video, audio and/or photo recordings may be taken.

RISKS, BENEFITS AND ALTERNATIVES.
The benefits of telemedicine include, but may not be limited to, having access to health care and additional medical information and education without having to travel outside of your home. A potential risk of telemedicine is that because of the patient's specific medical condition, or due to technical problems, a face-to face consultation may still be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a physician.

MEDICAL INFORMATION AND RECORDS.
All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.

CONFIDENTIALITY.
All existing confidentially protections under federal and California law apply to information used or disclosed during your telemedicine consultation.

RIGHTS.
You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consult without affecting your right to future care or treatment, or risking the loss or withdrawal of any benefits to which you would otherwise be entitled.

I have read and understand the information provided above. I understand that I am encouraged to ask questions of my physician about this information, should I have any. I have read and hereby agree to telemedicine consultation.

_____	_____	_____
Signature of adult Patient/Parent/Guardian	Printed name of adult Patient/Parent/Guardian	Date

_____	____/_____/_____
Child's Name	Date of Birth
_____	____/_____/_____
Child's Name	Date of Birth
_____	____/_____/_____
Child's Name	Date of Birth